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ABSTRACT

This monograph analyzes an experimental program that ran from 1976 to 1980 to train Pacific/Asian American social work students in community mental health. The students, who were awarded stipends, were recruited from three associate in arts programs in human services and from two universities that offered both bachelor's and master's programs in social work. Like many other minority community-based training programs in mental heath that emerged in the late 1960s and 1970s, this educational experiment was closely linked to the development of the community mental health movement and to social change in Pacific/Asian communities. Two sample surveys were conducted for the study, one of the students, and the other of the staff, council members, and field work supervisors of the center. Files and records of the center were examined and a number of individuals were interviewed intensively. Chapter 1 presents a historical survey of the development of the community mental health movement. Chapter 2 places the development of the training center in the context of social change in Pacific/Asian communities. Methodology and analysis of data are explained in Chapters 3, 4, and 5. Chapter 6, the concluding chapter, discusses the implications of this training experience. Data are presented on 22 tables and figures. Appendices provide the following: (1) the center's council by-laws; (2) intensive interview schedule; (3) survey of former stipend students; and (4) program evaluation questionnaire. Extensive references are included. (BJV)

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Minority Community Mental Health Training: Analysis of an Educational Experiment

Paul Wong

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Minority Community Mental Health Training: Analysis of an Educational Experiment

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Paul Wong

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To Takeo Wong

The elite defend a *sui generis* democracy, in which the people are "unwell" and require "medicine"—whereas in fact their "ailment" is the wish to speak up and participate. Each time the people try to express themselves freely and act, it is a sign that they continue to be ill and thus need more medicine. In this strange interpretation of democracy, health is synonymous with popular silence and inaction.

If a social worker (in the broadest sense) supposes that s/he is "*the* agent of change," it is with difficulty that s/he will see the obvious fact that, if the task is to be really educational and liberating, those with whom s/he works cannot be the objects of her actions. Rather, they too will be agents of change. If social workers cannot perceive this, they will succeed only in manipulating, steering, and "domesticating." If on the other hand they recognize others, as well as themselves, as agents of change, they will cease to have the exclusive title of "*the* agent of change."

Paulo Freire, *Education for Critical Consciousness*

Contents

Illustrations and Tables x
Preface xi

1 The Community Mental Health Movement and Minority Response 1
2 Social Change in Pacific/Asian American Communities and the Development of the Coastal Community Mental Health Center 15
3 An Evaluation of the Training Center: Methodology 31
4 The Students' Training Experience: The Correlates of Satisfaction and Impact on Professional Career 43
5 An Evaluation of the Training Center: Views of the Staff, Council Members, and Field Supervisors 59
6 The Implications of the Training Experience 83

Appendixes

1 Coastal Community Mental Health Training Council Bylaws 99
2 Intensive Interview Schedule 103
3 Survey of Former Stipend Students 107
4 Program Evaluation Questionnaire 117

References 129

Illustrations

1 Organizational Structure of the Training Center 24
2 Schematic Diagram of the Evaluation Procedure 37

Tables

1 Population Increases from 1970 to 1980 for Chinese, Pilipinos, Japanese, and Koreans 16
2 Asians and Pacific Islanders in the United States, 1980 17
3 Student Survey: Percent Distribution of Selected Characteristics of the Population and the Sample 39
4 Program Survey: Percent Distribution of Selected Characteristics of the Population and the Sample 40
5 Percent Distribution of Students by Income Level at Time of Survey, 1979 44
6 Percent Distribution of Students by Prior Experience in Asian American communities 45
7 Percent Distribution of Students by Current Major Field of Practice 47
8 Correlations Between Students' Ratings of the Field Personnel 50
9 Students' Evaluation of Their School's Social Work Curriculum 51
10 Correlations Between Students' Overall Evaluation of Professional Preparation and Specific Aspects of the Training Experience 52
11 Program Survey: Successfulness of Center in Achieving Goals 62
12 Program Survey: Training Center's Service to Different Levels of Students 65
13 Program Survey: Supportiveness of Colleges to Training Center 68
14 Program Survey: Impact of Training Center on Schools of Social Work 68
15 Program Survey: Training Center's Service to Asian/ Pacific American Communities 71
16 Program Survey: Adequacy of Representation of Each Asian/ Pacific American Community in the Training Center 72
17 Program Survey: Staff Performance 75
18 Program Survey: Council Performance 77
19 Zero-Order Correlations Between Training Center Performance Evaluation Indexes 79
20 Factor Matrix from a Factor Analysis of the Eight Performance Evaluation Indexes 80

Preface

In this book, I have analyzed a particular experiment in minority community mental health training. It took place in a coastal area of the United States. To protect confidentiality and maintain anonymity as much as possible, a fictitious name has been assigned to the training center, the Coastal Community Mental Health Training Center, and the names of the individuals who were interviewed have not been revealed.

The training center was an educational experiment funded by the National Institute of Mental Health (NIMH) for a five-year period (1976 to 1980). Its major goal was to train Pacific/Asian American social work students in community mental health. The students, who were awarded stipends, were recruited from three associate in arts programs in human services and from two universities which offered both bachelor's and master's programs in social work.

Like many other minority community-based training programs in mental health which emerged in the late sixties and in the seventies, this educational experiment was linked closely to the development of the community mental health movement and to social change in Pacific/Asian communities. Minority community mental health training programs have been reduced drastically and, in many respects, phased out by the Reagan administration. A detailed analysis of the experience of the Coastal Community Mental Health Training Center may provide some insights about the viability and potential of minority community mental health training. Two sample surveys were conducted for this study, one of the students and the second of the staff, council members, and field work supervisors of the center. Files and records of the center were examined and a number of individuals were interviewed intensively. Methodology and analysis of data are explained in chapters 3, 4, and 5.

This study goes beyond the conventional aims of program evaluations. I have undertaken a historical survey of the development of the community mental health movement and the response to the movement by minority communities (chapter 1). I have also placed the development of the training center in the context of social change in Pacific/Asian communities. Finally, in the concluding chapter (chapter 6), I have discussed the implications of this training experience.

This book can be considered a modest beginning of much more extensive research on the impact of social welfare expenditures on minority communities. The plans for the larger project are being prepared.

1

The Community Mental Health Movement and Minority Response

This chapter gives a historical overview of the concept of community mental health. Since minority community mental health training emerged within the context of the community mental health movement of the past two decades, such an overview is essential to an appraisal of the strengths and weaknesses of the Coastal Mental Health Training Center.

Definitions of Community Mental Health

Numerous conceptual definitions of community mental health have been developed in the past two decades. Recently, Steven Segal, a mental health scholar in the field of social work, offered the following (1981:168):

> Community mental health is a human services ideology concerned with mental well-being. Unlike treatment ideologies which focus on the individual's psyche, community mental health is unique in its focus on the individual's relationship to the social and physical environment. Community mental health practitioners view individuals in their social contexts and, to some extent, have adopted and developed, at least in theory, a combination of the social work and public health approaches to helping. In developing this new approach to helping, the community mental health movement reoriented the delivery of mental health service in several ways. It moved the focus of service out of the state mental hospital and the private psychiatrist's office into the local community, expanded the concept of mental health problems from a narrow focus on psychological etiology to an ecologically minded perspective, expanded the types of problems thought of as mental health related, expanded on the types of individuals receiving service, and developed new service strategies.

Conceptual definitions of community mental health have also been developed by scholars in the field of community psychiatry. For example, Hirschowitz (1970) described it as:

> any mental health enterprise primarily concerned with promoting mental health and preventing mental illness in the community, identifying

and treating persons with mental illness, and reducing the residual disabilities or promoting the intact capacities of those who have a chronic mental illness, disease or defect.

The Langley Porter Neuropsychiatric Institute in San Francisco (cited in Bloom 1977:4) defined community mental health as:

> the broad multidisciplined field concerned with the wide variety of forces and structures in a community which affect the emotional stability (positive growth, development and functioning) of a significant group of its members. . . . The attention is directed at social institutions including those concerned with welfare, health, legislation, minority groups, employment, education, church, and their interactions which can in their functioning either enhance or hinder the emotional growth of a large segment of the population.

Finally, a very useful definition of community mental health, developed by S. R. Roen (1965:2), founding editor of the *Community Mental Health Journal*, appeared in the first issue of that journal. Roen says that this approach to mental health involves:

- Preparing activities to prevent and control mental disorders.
- Understanding community organization.
- Utilizing basic epidemiological studies in the field of mental illness.
- Offering comprehensive mental health services.
- Involving the community in planning and decision-making.
- Assuring continuity of care.
- Developing an optimal milieu for human growth and development.
- Training people to deliver mental health services.
- Seeking supporting legislation.
- Developing and evaluating models of personal/community interaction.

The Historical and Theoretical Roots of Community Mental Health

It is useful to place the development of minority mental health training within the context of the emergence of community mental health as a new and unique mental health system (for a review of this, see Feldman and Goldstein 1971).

The relationship between the social environment and mental disorders was examined theoretically by Emile Durkheim about a hundred years ago ([1893] 1933, [1897] 1951). The effect of the community on the incidence and prevalence of mental illness was recognized at least as early as the 1930s. Faris and Dunham (1939) studied the relationship between social disorganization and rates of mental illness. Malzberg, in an important work ([1940] 1979),

produced a series of statistical studies on the relationship between mental illness and such factors as age, ethnicity, race, class, and various forms of treatment. A number of studies on the relationship between migration status and insanity were also undertaken (e.g., Odegaard 1932). These studies on migration status and mental illness in the 1930s can be considered as a continuation of earlier works on the same subject (Grob 1980).

A recently republished collection of studies on historical issues in mental health (Grob 1979) indicates that although there were widespread medical and social misconceptions about mental health and mental illnesses among professionals in the first half of this century, there was also some innovative work on theories and methods. For example, while it was common to explain mental illness either in terms of the classical medical model or to resort to nonrational, ad hoc explanations, significant studies on the impact of environmental conditions, social as well as economic, on mental health were conducted.

In terms of service delivery, community-based mental health programs also have historical antecedents. A community-clinic movement, designed primarily to provide mental health services for children, began in 1896 (Bloom 1977:19). Other service delivery models which closely resemble recent community mental health programs were also developed. They include, for example, the community mental hygiene district proposed by Adolf Meyer in 1915. His model integrated services at the community level to prevent mental disorders and to foster mental health (Rossi 1962).

Since the 1950s, there has been continuing controversy about the definition of mental illness, as well as policies and programs for the mentally ill. Some scholars have argued that individuals who deviate from established normative behavior are simply labeled as mentally ill (Scheff 1966). Other scholars, such as Goffman (1962, 1963), have examined the stigma and social degradation connected with institutionalization.

The medical model has even been criticized by psychiatrists. Perhaps the most important such critique is Szasz's ([1961] 1974) penetrating appraisal of psychiatry from a moral and ethical standpoint. In the mid-1950s, Garfinkel (1956) described the treatment of the mentally ill as a process of social degradation that involved removing individuals considered mentally ill from their communities, stripping them of their bases of social support, and imposing upon them identities as insane inmates in a prison setting.

Garfinkel's and Goffman's theoretical work was preceded by muckraking exposes of mental institutions by Ward (1946) and Deutsch (1948) a decade earlier. Ward's book, *The Snake Pit*, was made into a film in 1948. During the 1950s, in criticizing mental institutions as prisons, the English formulated an alternate model of the mental hospital as a therapeutic community without walls or other barriers (Rapaport [1960] 1979, Jones 1953).

One of the important implications of these studies on labeling, stigmatization, and the ecological context of mental health in the late 1950s and the 1960s was that new approaches to mental health care were needed. These studies provided theoretical support for establishing treatment facilities within the natural environment of those being treated; that is, in the communities and neighborhoods where they resided. The assumption was that in their own environments patients would be less likely to be deprived of the social networks they might be able to draw upon for support. From a systems perspective, the strong informal support networks such as the extended family, the clan, friendship circles, and community self-help groups were identified by advocates of this community-oriented approach to mental health as essential foundations of a mentally healthy community.

As the community mental health movement developed, increasing attention was given to the relationship between formal therapeutic facilities and these informal support networks (Collins and Pancoast 1976; Caplan 1974). The integration of informal support networks with formal therapeutic facilities came to be regarded as a major factor in the improvement of a community's mental health and in the successful clinical treatment of individuals and families. This viewpoint about community and individual mental health called into question the classical psychiatric approach to mental illness based on the medical model.

Ironically, while the community mental health movement criticized many assumptions of the medical model, it benefited directly from psychopharmacological research. The efficacy of the major tranquilizers—the phenothiazines—in controlling psychotic symptomatology provided the justification for placing treatment services in local communities on the grounds that public safety could now be insured (Segal 1981:170).

A number of very important empirical studies on the relationship between social factors and mental illness were conducted in the late 1950s. These included a study by Hollingshead and Redlich (1958), which examined the relationship between social class and mental illness, and the Midtown Manhattan study, which examined the relationship of ten stress factors to the prevalence of mental illness (Srole et al. 1962).

However, there were virtually no studies on the relationship between ethnic/cultural factors and the effectiveness of mental health treatment methods. In some respects, the emphasis on assimilation that characterized the civil rights movement of the 1950s contributed to a "color-blind" outlook among social and behavioral scientists concerned with mental illness.

It is important to mention the influence of the public health model on community mental health. Community mental health aims to reach a much broader population than the traditional mental health model, which focuses on

the severely disturbed. Community mental health, like public health, is concerned with prevention. In fact, public health concepts of primary, secondary, and tertiary prevention have been applied to it (Segal 1981:178). Primary prevention seeks to reduce the incidence of mental illness; that is, the number of new cases beginning within a given period of time within a population. Secondary prevention seeks to reduce the prevalence of mental illness, that is, the number of cases, including new cases, at a given time. Tertiary prevention focuses on reducing the overall level of mental illness within a community.

In order to maintain a certain level of funding or to secure additional funding, community mental health centers have had to demonstrate that the incidence and prevalence of mental illness are much higher than shown in official statistics. For this reason, mental health prevention has been intrinsically linked to advocacy for the expansion of facilities and staff. The link between high-risk populations (particularly minority and low income groups) and underutilization, or the discrepancy between the level of services needed and the level used, has been shown in many needs assessment studies (Abad, Ramos, and Boyce 1974; S. Sue 1977; Padilla, Ruiz, and Alvarez 1975; President's Commission on Mental Health 1978a; Southern Regional Education Board 1978).

To sum up from a historical perspective, the basic assumptions of the community mental health movement were not entirely new. The importance of environmental, social, and economic factors in mental health was identified in earlier theoretical and empirical research. As a whole, community mental health borrowed extensively from the social and behavioral sciences as well as other allied fields, such as public health, in developing a new model of service, training, and research.

Perhaps what was lacking in the earlier decades was the political and grass-roots support which eventually created the infrastructure for a new approach to community mental health in the 1960s and 1970s. In this respect, the community mental health movement was linked to the minority social movements of that period. Although those movements were influenced by many ideologies and political currents—such as Kennedy liberalism, Marxism-Leninism, internal colonialism, and the Gandhian nonviolent perspective—they shared the view that basic institutional changes were necessary to improve the conditions of minorities in the United States. There was a widespread belief that the social programs of this country were not responsive to and, in fact, repressed the needs of minority groups. Even though some new institutional structures were created, the federal actions to fight poverty, to improve ghetto schools, and to expand social programs were seen essentially as efforts to defuse the revolutionary impulses of the minority social movements and assimilate them within the bounds of the existing system.

Such direct federal intervention into local—particularly minority—communities did have precedents in the New Deal and, later, in the civil rights movement of the 1950s. Federal involvement in mental health policy began as early as 1946 with the establishment of the National Institute of Mental Health (NIMH) to encourage research and innovation. However, federal action in the area of mental health in the 1960s should be seen within the volatile social and political climate of that period.

Legislative Action for the Development of Community Mental Health

A major turning point in the development of community mental health was the Mental Health Study Act enacted by the United States Congress as a result of increasing public awareness and concern about mental disorders (Feldman and Goldstein 1971:247). This act established the Joint Commission on Mental Illness and Health which, after five years of study, reported its findings in *Action for Mental Health* (1961).

In October 1963, the Community Mental Health Centers Act was enacted by Congress and signed into law. It authorized funds to be administered in the construction of community mental health centers. These community mental health centers were distinct from traditional mental health facilities in six important respects:

1. They served geographic areas, termed catchment areas, with populations of no fewer than 50,000 and no more than 250,000.
2. They provided essential aid in terms of emergency services, consultation and educational programs, out-patient and inpatient services, and partial hospitalization.
3. They ensured accessibility.
4. They provided continuity of care to insure that patients would be able to move among service units freely and effectively.
5. They involved the community in planning, development, and operation of the centers.
6. They coordinated the services of a number of different community agencies to provide an integrated system.

Five additional areas were listed in the legislation as part of the definition of a comprehensive mental health center: diagnostic services, rehabilitative services, precare and aftercare services, training, and research and evaluation.

The 1963 act required that federal funds be allocated to communities as seed money, to be matched by local dollars. The percentage of local match of federal money was to be increased each year. In 1965, legislation creating

staffing grants for community mental health centers was passed. It provided for federal matching of local contributions, and, as with the 1963 act, the local share of staffing support was also to be increased every year.

The 1963 act was extended by the Mental Health Amendments of 1967 (Public Law 90–31), which authorized funds for three more years of construction support and two more years of staffing support for mental health centers. In 1968, the Alcoholic and Narcotic Rehabilitation Amendments (Public Law 90–574) supported the construction and staffing of prevention and treatment programs for alcohol and drug addiction. These programs were to be integrated into the local community mental health centers. Alcoholism and drug abuse services were later expanded by the passage of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

In 1970, recognizing that local community mental health centers would need a long period of federal support before they could become financially independent, amendments were passed to extend the community mental health action by three years and to increase the federal share for construction and staffing.

In 1975, significant amendments (Public Law 94-63) to the Community Mental Health Act were passed by Congress over the veto of President Ford. These amendments mandated the continuation of federal support for the community mental health centers program. In addition, they stipulated the delivery of twelve essential services, adding screening and the provision of community living arrangements to the original list of ten comprehensive services (five of which were regarded as essential to the operation of a community mental health center). Six grant mechanisms were specified in the 1975 amendments. Among other things, these grant mechanisms allowed for more flexibility in grant administration, greater emphasis on planning and on consultation and education designed to encourage prevention, and more support for the development of service capacity in all twelve essential areas. The 1975 amendments also gave more emphasis to accountability by providing that at least 2 percent of the community mental health center budget be set aside for evaluation.

In addition to federal legislation, state legislation—particularly in New York, California, and Wisconsin—also significantly facilitated the development of the community mental health movement.

By 1975, there were 528 federally funded community mental health centers, of which 20 percent had been operating for eight or more years, 23 percent for six to seven years, 34 percent for three to five years, and 23 percent for one to two years (NIMH 1977). While state hospitals continued to provide the bulk of services to the severely disturbed, by 1975 community mental health centers had become the main provider to a broader-based population.

In terms of staffing, the largest group of professionals employed by community mental health centers were social workers with master's degrees, followed by nurses. Psychiatrists made up 3 percent of the full-time staff but 20 percent of the part-time staff (Segal 1981:185). However, the most significant development in community mental health staffing patterns was that one-fourth of the full-time staff were paraprofessional mental health workers with less than a bachelor's degree (Segal 1981:185). In many cases, these paraprofessionals were recruited from the communities in which the centers were situated.

As the number of community mental health centers grew, it became apparent that this new and nontraditional approach to mental health treatment necessitated special training for the professionals who were already in the field. Some 67 percent of the staff in community mental health centers reported gaps in their training (Feldman and Goldstein 1971:254). One of the problems was that community mental health centers tended to require staff members with interdisciplinary skills, rather than narrow specializations. However, even more serious was the fact that the staff members of many community mental health centers were not trained to serve the special needs of minority communities and the poor, as reported in the Nader study (Chu and Trotter 1974). Staff members recruited from the local community tended to fill mainly paraprofessional positions. There were not enough training programs to upgrade the skill level of the indigenous paraprofessionals to the higher professional ranks, even though some new career opportunities were created for them.

During the late 1960s and early 1970s, many minority community protests against community mental health programs occurred, the most well known of which were perhaps the 1969 community "take-overs" of the Lincoln Hospital Community Mental Health Center in New York and the Temple University Mental Health Center in Philadelphia (Shaw and Eagle 1971, Kaplan and Roman 1973, Panzetta 1971). Because of these confrontations and incidents, the problems of community control, equity of funding, quality of services, propriety and applicability of treatment methods, and training of minority mental health workers began to attract the attention of national legislators and policymakers.

As one response to these issues, in Public Law 94–63, the 1975 Amendments to the Community Mental Health Act, a provision was made to insure consumer dominance in the governing bodies of community mental health centers by giving these bodies the right to select the center director and approve the budget. Another provision insured that bilingual staff would be available in areas with a substantial proportion of individuals of limited English-speaking ability.

The Minority Response: The Theoretical Premises of Minority Community Mental Health

Minority groups responded to the development of the community mental health movement in the 1960s and 1970s on several points. They criticized the insufficient theoretical attention given to minority issues in government community mental health policies. In this regard, it is important to mention that the influential 1961 report of the Joint Commission on Mental Health and Illness that shaped mental health policies for many years included no direct investigation of either racial minority policy concerns or clinical issues involving minority groups.

In response to this neglect on the national level, minority individuals and organizations involved in community mental health began themselves to address a number of issues about the nature of mental illness and methods of treatment with respect to minority groups.

A review of the literature on minority community mental health reveals eight basic theoretical premises that were commonly shared by individuals and organizations advocating programs for minority community mental health:

1. In addition to having a medical aspect, mental illness, like deviance, is socially and culturally defined.

2. The prevalent definition of mental health and illness, like deviance, is based on the dominant Anglo views about what is normal behavior.[1]

3. In the mental heath field and in related social and behavioral sciences, there is a tendency to emphasize the social and individual pathology of minority groups and to neglect their healthy adjustment as well as positive methods of coping with the problems of living in a racist environment (see Montiel and Wong 1983, n.d.; Wong 1982).

4. Because mental illness is socially and culturally defined, what is conceived as mental illness or healthy behavior by the dominant Anglo society may not apply to culturally different groups (Sanchez 1971).

5. Similarly, since mental illness is socially and culturally defined and since social and cultural factors may have different impacts upon various ethnic groups, mental health service delivery must take into account this diversity in order to be effective.

6. Because of past neglect, sufficient attention has not been given to the cultural factors involved in mental health and to culturally relevant treatment modalities. Mental health service delivery, training, and research in minority communities should focus on the development of culturally relevant and effective theories as well as methods.

7. To overcome the biases and distortions in the theories and methods of mental health, minority communities must be able to control the infrastructures of mental health care that result from federal policies.

8. Broad participation and grass-roots support are essential for the development and control of effective mental health services in minority communities.

As far as the definition and etiology of mental illness are concerned, at least two different views were advanced by minority community mental health advocates. One of these views was derived from internal colonization theories and emerged originally from the black power movement in the late 1950s. During the 1960s, this view was adopted by Asians, Chicanos, American Indians, and other minority groups. The proponents of this view of mental illness were inspired particularly by the writings of Franz Fanon (1963, 1967), the Algerian psychiatrist who wrote extensively on the psychopathology of colonization based on his clinical experience. Fanon's views were popularized in the black movement by Stokely Carmichael (1967) and others.

According to Fanon and other anticolonization theorists, the behaviors of individuals and groups living within a colonial system are circumscribed by the norms of social relationships that are considered legitimate within that system. These norms define the social relationships between the colonized groups and the colonizers in terms of dominance and subordination. When either the colonized or colonizers challenge the unequal and oppressive norms, they tend to be perceived as abnormal. The colonizer and the colonized become distinct and opposite personality types. For this reason, political consciousness-raising becomes a very important part of the treatment of those who suffer from the colonization syndrome. Furthermore, according to this view, mental health problems in this society cannot be solved without basic changes in the political-economic system. It is easy to discern the similarity between this view and certain types of feminist therapy. Both are concerned with the effects of systemic oppression on mental health.

In the 1960s and early 1970s, some individual practitioners and community mental health programs incorporated this view of internal colonization into their treatment methods. On the one hand, social and political consciousness-raising was built into the clinical programs. On the other hand, consciousness-raising and political action were carried out into the community. However, as minority social movements lost some of their momentum by the mid-1970s due partly to the co-optation of their leadership into governmental programs, the internal colonial perspective of minority mental health was replaced by a cultural pluralist perspective (for a discussion of the evolution, see Montiel and Wong 1983).

The main thrust of minority community mental health since about the mid-1970s has been toward the development of parallel programs of service, training, and research for each minority group. This particularistic approach adopted by minority community mental health advocates was based on the assumptions that (1) mental illness is culturally defined, and (2) therapeutic methods must be consistent with the cultural background and experience of the group being treated.

Looking at this from a different vantage point, it would seem that by putting mental health into a cultural context, minority mental health professionals were also seeking a legitimate, stable, and permanent share of the public allocations for mental health services, training, and research.

Minority Community Mental Health: Issues in Service, Training, and Research

A review of the minority community mental health literature of the 1960s and 1970s reveals some issues and concerns common to all minority groups. Many were unique to minority groups and flowed from the theoretical premises discussed in the previous section of this chapter. Some were shared by the community mental health movement as a whole. The following were the most salient:

1. The development of theoretical frameworks for minority mental health, including the conceptualization and etiology of mental illness. In attempting to develop theoretical frameworks, minority scholars had to distinguish between propositions about mental health which were universal—that is, applicable to all racial and ethnic groups—from those which were particular—that is, applicable to specific cultural groups. More often than not, minority scholars were critical of the theoretical overgeneralizations of previous research, and they introduced many concepts (e.g., *curanderismo, sobardero, brujo-a*, and *quetzacoatl*) which cast doubt on the validity of any universal theory of mental illness and treatment.

2. The development of treatment approaches for specific ethnic groups based on their culture, such as acupuncture (Chinese), Morita therapy (Japanese), and *curanderismo* (Mexican). Efforts were also made to develop curriculum materials and to train mental health professionals in these approaches.

3. The adaptation and modification of existing treatment approaches to the treatment of minority clients. While some minority practitioners were concerned with the development of new treatment approaches, others devoted attention to the adaptation and modification of existing approaches—such as

transactional analysis, reality therapy, Gestalt therapy, behavioral modification, Freudian psychoanalysis, and rational-emotive therapy (see, for example, Southern Regional Education Board 1978).

4. The question of accountability for services and the utility of technological innovations such as management information systems and evaluation methodologies to measure such accountability. This became a very important issue for community mental health by about the middle of the 1970s. However, while minority groups were concerned about accountability, they tended to be slow in applying technological innovations to community mental health practice.

5. The question of macro versus micro research in minority community mental health. At the beginning of the community mental health movement, research emphasized the impact on mental health of macro variables such as poverty, social change, unemployment, racism, and sexism. By the mid-1970s, there was a shift toward micro or clinical research, particularly that based on statistical designs. On the issue of micro versus macro research, minority scholars were, depending on their ideological and methodological orientations, divided in opinion. The funding priorities in mental health have increasingly favored micro research based on quantitative designs. After 1980, the support for research on the structural factors affecting mental health was reduced very substantially.[2]

6. The promotion of legislative and organizational changes to improve minority community mental health through national meetings on minority community mental health and the submission of major reports and policy recommendations to the federal government.[3] The basic thrust of these efforts was to ensure that minority mental health professionals would have direct communication with high-level government officials and would be represented on major organizational levels.

7. The advancement of minority mental health professionals and the establishment of minority mental health as a legitimate subfield within mental health. The importance of this issue was manifested in several ways, including: demands for the hiring of minority professionals at all levels of the national mental health system; national meetings held by minority mental health professionals to discuss issues in service delivery, training, and research; and the demand for and successful development of minority research/training centers, programs, and projects throughout the United States.

8. The maintenance of grass-roots support and enthusiasm for the community mental health movement within minority communities. As minority mental health became more professionalized, this emerged as a critical issue. Many former activists of the mental health movement became administrators

and professionals in funded programs. New practitioners tended to have a professional rather than a social movement orientation toward community mental health. The viability of community mental health as a social movement with a broad support base became problematic.

9. The integration of community mental health services with other human services and with other institutions in minority communities. This concern was intrinsically linked to the issue of maintaining a broad support base for community mental health. The effectiveness of community mental health programs were, in many respects, dependent on how well these programs were integrated into the overall formal and informal institutional framework of a minority community.[4]

10. The development and maintenance of a stable economic base for community mental health programs. In minority communities, the economic difficulties in mental health programs were compounded by the fact that, quite often, the infrastructures for service, training, and research had to be constructed from scratch with few existing resources to draw upon.

Summary

In this chapter, the historical and theoretical antecedents of the community mental health movement are examined. Not only was the community mental health movement of the last two decades significantly influenced by social and behavioral theory and research in the 1950s and 1960s, but also many ideas akin to the movement dated back to the first half of this century and even to the nineteenth century. It was in the political and economic climate of the 1960s and 1970s that the developing theoretical model of community mental health found support mental health professionals on the one hand and among politicians and legislators on the other.

Minority communities responded to the community mental health movement on several fronts. Some basic theoretical premises about minority community mental health were identified and reflected in the publications of minority mental health scholars and practitioners. In terms of issues in service, training, and research, common themes and concerns extended throughout all minority groups. In many respects, the issues confronted by the Coastal Community Mental Health Training Center in the course of the five years of its existence were common to those experienced by other minority community mental health service, training, and research programs.

Notes

1. See, for example, Sanchez (1971:8). Sanchez states that "mental health for the Chicano community exists in the full awareness of itself as a distinct ontological entity with its philosophy of man, nature and universe. A corollary of the full awareness is the full realization of its power of self-determination."

2. The United States government's de-emphasis of the structural factors which affect mental health was challenged by minority community mental health groups. For example, in the 1978 report of the Subpanel of Mental Health of Asian/Pacific Americans, the authors raised serious questions about why basic, systemic, causal factors within American society, such as racism, were not sufficiently addressed in the charge to the Task Panel on Special Populations of the President's Commission on Mental Health (President's Commission on Mental Health 1978b).

3. This includes, for example, the important reports of the minority subpanels of the President's Commission on Mental Health (1978a, 1978b).

4. The adaptive models of service delivery described by Padilla, Ruiz, and Alvarez (1976) are examples of attempts to integrate community mental health programs into the formal and informal institutional frameworks of the barrios.

2

Social Change in Pacific/Asian American Communities and the Development of the Coastal Community Mental Health Training Center

This chapter will examine the conditions in Pacific/Asian American[1] communities that led to the establishment of the Coastal Community Mental Health Training Center. In the late 1960s and in the 1970s, Pacific/Asian communities were characterized by a climate of change, both in political consciousness and in objective conditions. The involvement of Pacific/Asian Americans in the mental health movement was a reflection of these social changes, and the history of the Coastal Community Mental Health Training Center must be viewed within this context.

Social Change in Pacific Asian/American Communities

The political persecution of the McCarthy era, combined with the relative economic stability of this period, produced a climate of political noninvolvement in Asian American communities through the middle of the 1960s. Some Asian Americans had participated in the civil rights movement, but it was not until the late 1960s that individuals and organizations were able to coalesce around a number of issues, such as ethnic studies, the antiwar movement, community control of schools, and union organizing in the ghettos (Wong 1972). At this time, progressive Asian American political organizations were formed on a number of university campuses.

Two important aims of these organizations were to serve Asian American communities and to mobilize their residents into political and social action. By 1969, some "storefront" community centers had opened in inner cities with large concentrations of Asians, such as Nihonmachi and Chinatown in San Francisco, Little Tokyo in Los Angeles, and Chinatown in New York. The new activists sought to dispel the myth promoted by traditional political leaders that Asian American communities were free of the social and economic problems plaguing other minority and poor communities— unemployment and underemployment; low wages; juvenile delinquency; and inadequate health and mental health facilities, schools, housing, and recreational

outlets. They shattered the traditional stereotypes that Asians "have no problems" or that Asians "take care of their own."

Significant demographic and economic changes were also occurring during this period and into the 1970s. Pacific/Asian American communities were experiencing a tremendous population growth, due mainly to immigration. For the groups for which data are available, the population increases from 1970 to 1980 were 85.3 percent for Chinese, 125.8 percent for Pilipinos, 18.5 percent for Japanese, and 412.8 percent for Koreans (see Table 1). The high influx of Indochinese refugees into the United States in the mid-1970s eventually led to the formation of refugee communities, in spite of the federal government's policy to disperse this population.

Table 2 shows the population of Pacific/Asian nationalities and groups in the United States in 1980. A number of Pacific/Asian groups are not included because the constituents of the *Pacific/Asian American* designation are constantly changing. In one study conducted in 1981, 29 distinct ethnic, cultural, national, and regional groups were identified (Yoshioka, Tashima, and Chew 1981:1-5).

Between the late 1960s and 1980, the Pacific/Asian American population grew dramatically in terms of both size and diversity. For example, between 1960 and 1970, while the number of elderly in the United States grew at a

Table 1
Population Increase from 1970 to 1980 for Chinese, Pilipinos, Japanese, and Koreans

	Number		Change from 1970 to 1980	
Nationality	1970	1980	Number	Percent
Chinese	435,062	806,027	370,965	85.3
Pilipino	343,060	774,640	431,580	125.8
Japanese	591,290	700,747	109,457	18.5
Korean	69,130	354,529	285,399	412.8

Source: U.S. Bureau of the Census (1981:13)

faster rate than the national growth rate, the number of Chinese, Japanese, and Pilipino elderly grew at from three to five times this rate (Pacific/Asian Elderly Research Project 1978:9). Further demographic analyses showed not only that the Pacific/Asian elderly in many instances were worse off economically when compared to the total elderly population, but also that social factors such as language barriers, educational difficulties, and the lack of family networks compounded this problem (1978:23).

It was estimated in 1981 that 60 percent of all Chinese Americans, 70 percent of all Pilipino Americans, and 90 percent of all Korean Americans were first generation Pacific/Asian Americans, and, as such, constituted epidemiologically high-risk populations (Yoshioka, Tashima, and Chew 1981:I-7). Nearly all of the country's 420,000 Southeast Asian immigrants were at high risk, and it is they who most graphically represented the spectrum of problems facing Pacific/Asian Americans (1981:I-7).

It is easy to see how these demographic and economic changes could render existing resources for health, education, and welfare programs inadequate. Traditional mutual aid institutions and small-scale public and private programs could not provide the needed services to such a vastly expanded and diversified population. Because of this situation, Asian American activists decided to organize their communities to fight for an equitable allocation of

Table 2
Asians and Pacific Islanders in the United States, 1980

Nationality or Group	Number	Percent
Chinese	806,027	23.0
Pilipino	774,640	22.1
Japanese	700,747	20.1
Asian Indian	361,544	10.3
Korean	354,529	10.1
Vietnamese	261,714	7.5
Hawaiian	167,253	4.8
Samoan	42,050	1.2
Guamanian	32,132	0.9
Total	3,500,636	100.00

Source: U.S. Bureau of the Census (1981:7)

public and private funds for a variety of programs.

They precipitated a veritable "Asian American movement" for greater equality in the allocation of available resources that brought about a period of intense political and social involvement among a large number of Asian Americans. These included students; professionals in the health care, education, and welfare fields; and working people from inner cities. In terms of ideology, organization, and leadership, the development of community mental health programs was linked closely to the Asian American movement.

The Impact of the Asian American Mental Health Conference of 1972

In April 1972, the Asian American Social Workers (AASW), in conjunction with the newly formed Center for Minority Group Mental Health Programs of NIMH, sponsored the First National Conference on Asian American Mental Health (NIMH 1974a:1). At that time, AASW was the sole Asian American organization in the area of the behavioral sciences that had members from Chinese, Pilipino, Guamanian, Japanese, Korean, Samoan, and Pacific Island communities across the nation.

For Pacific/Asian Americans, the 1972 conference provided a focal point for many local community struggles over mental health programs. Bertram S. Brown, then director of NIMH, remarked about the conference (NIMH 1974a:i):

> While 81 participants had been "invited," the 600 and more who attended contributed greatly to an overwhelming experience. It was one which gave me a special dose of sensitization to what had been mostly an amorphous entity—the community.

Resolutions were passed in the conference giving priority to manpower training as a necessary step in resolving the problems that faced Pacific/Asian American communities. The question of self-determination was a central concern and a recurrent theme of the conference. One resolution (NIMH 1974a:20) was that:

> all mental health programs in Asian American communities should be controlled by the "grass-roots" community people; funding sources, such as NIMH, should communicate directly with local groups for program development, implementation, and evaluation.

Among other things, this opened the door to community-based and community-controlled mental health training programs outside the traditional academic setting.

The 1972 conferences represented the first successful attempt to coordinate a national meeting for the Pan-Asian community (NIMH 1974a:9). It was especially important in light of the history of interaction among the various

Asian groups, which had been characterized at times by mistrust, competitiveness, and territoriality. The conference certainly did not resolve these problems. However, the recommended formation of a Pacific/Asian American Coalition for Mental Health indicated a recognition on the part of the various groups involved of their shared concern over service delivery, research, and manpower training. At the same time, an important theme of the conference was that the uniqueness and variations within the Pan-Asian community should be given sufficient attention.

The conference also addressed the issue of mental health in a very broad way. The problems presented at the conference included: underemployment and unemployment; low levels of academic achievement; drug abuse, delinquency, and "dropping out" among ghetto youth; substandard housing; the absence of adequate health and social care services within Pacific/Asian communities; the lack of research in Pacific/Asian American communities; the lack of opportunities for Pacific/Asian Americans to enter decision-making positions; the derogatory portrayal of Asians in the mass media; and the stereotyping of Asians (NIMH 1974a:14-15). A resolution to end the war in Southeast Asia characterized that conflict as immoral and racist and raised additional concerns about the development of racist attitudes by GIs and the effect of these attitudes on the well-being of Pacific/Asian Americans (NIMH 1974a:15).

In many respects, this conference facilitated the development of a Pacific and Asian American perspective on the scope and nature of mental health issues, as well as a set of priorities for training, research, and service delivery. It also provided the impetus for mobilizing the Pan-Asian community. As noted earlier, more than 600 people attended the conference, among whom were mental health specialists, social workers, community organizers, clergymen, teachers, students, and attorneys. This broad participation helped to demystify the mental health profession and to establish links between mental health problems and the other social and economic issues in Pacific/Asian American communities.

It should be pointed out that members of the new professional stratum in Pacific/Asian communities and students who would soon be joining this stratum were overrepresented at the conference, while the working class, the poor, and new immigrants were underrepresented. In fact, a number of organizations which had been in the forefront of the struggle for better labor, housing, and education practices did not attend, believing that the conference was organized by the federal government. They saw the conference as a government tactic to increase social control over Pacific/Asian communities, to defuse the mass movement in these communities for fundamental changes in society, and to promote community conflicts over resources and funds. This

sentiment was echoed by some of the conference participants, but they did not articulate a unified minority position. They were also unclear about the relationship between reforms in specific areas, such as health care, and the struggle for structural changes in society.

The Report of the Asian American Task Force of the Council on Social Work Education

AASW, as a recognized national organization for Asian American social workers, played significant roles in the initiation, planning, and implementation of the 1972 conference. In addition, Asian Americans in the social work profession were spearheading other organized efforts at local and national levels. For example, the Asian American Task Force, one of five minority task forces of the Council of Social Work Education, made a vital contribution by identifying Asian American problems and proposing methods for their resolution (Kuramoto 1971; Murase 1973). In each of the four areas defined as being of major concern—community involvement, delivery of services, recruitment of students and faculty, and curriculum content—the task force made important recommendations. In many respects, its report (Murase 1973) can be used as a guideline for evaluating the general progress of the social work profession in serving Pacific/Asian communities in the following decade.

As far as community involvement is concerned, the task force recommended (Murase 1973:10) that schools of social work:

1. Consult with communities for the purpose of appointing community representatives to sit as full members of these schools' policy-making committees.

2. Develop, with the participation of these communities, field work placements for Asian American students.

3. Develop—with the participation of Asian communities, faculty, and students—research designs to determine the various problems and needs of these communities.

In order to provide autonomous direct service in each Asian American community and at the same time allow for a centralized integration of research and planning, the task force recommended the development of consortium-satellite delivery systems. The task force also emphasized the importance of recognizing the cultural diversity of various groups and the need to overcome the barriers that had led to underutilization of social services by Asian Americans. Finally, the task force recommended increased recruitment of Asian American students and faculty and development of curricula geared directly to working with Asian Americans.

It appears that the goals and objectives of the Coastal Community Mental Health Training Center conformed closely to most of the policy recommendations specified in the task force report. In this respect, the success of the training center in achieving its goals and objectives is a measure of the progress the social work profession has made in meeting the needs of Pacific/Asian communities.

The Asian American Social Work Training Project at University A as a Forerunner to the Training Center

Programmatically and organizationally, the Asian American Social Work Training Project established at University A in 1972 was the forerunner of the Coastal Community Mental Health Training Center. Since University A had been involved in both the training project and the coastal training center, it was in a strategic position to define and assess the nature and consequences of community involvement in social work education as exemplified in these two different models:

1. A school-based, school-controlled project, and
2. A community-based, community-controlled center (Murase 1977b).

Following the proposed guidelines on community involvement developed by an ad hoc committee of the Council on Social Work Education's Commission on Minority Groups (1973), Murase (1977b) analyzed the relationship between Asian communities and schools of social work along a three-stage continuum: communication, participation, and shared control.

In the case of the University A training project, which was established in 1972, Asian communities were able to exert pressure on the school and gain the right to participation: the project's Advisory Community Board was composed of representatives of the Asian communities and Asian social agencies, and of the university's administration and Department of Social Work. However, the Asian representatives shared actual control only in the field placement process (Murase 1977b).

In the fall of 1974, recognizing that the three-year training project would be terminated by 1975, and feeling frustrated by the limited community participation, some Advisory Community Board members recommended establishing a metropolitan, area-wide, community-based, community-controlled training center. This coincided with the cancellation of the NIMH minority training grant at the School of Social Welfare at University B—the result of a massive lobbying effort on the part of many Asian community leaders. It seemed that the social and political conditions were ripe for an experiment in

community-based and community-controlled social work training. As Murase observed (1977b), "In terms of the concept of community involvement, the new training center represented for the Asian community a further movement along the continuum of community involvement towards the final stage of shared control."

The Conflicts Between Asian American Students and the Faculty-Administrators of the School of Social Work at University B

As noted earlier, the indirect and direct factors which led to the founding of the training center were numerous. However, the decision of the National Institute of Mental Health to terminate the training grant at the School of Social Welfare of University B due to the protests of the Asian Student Caucus and Asian communities over that school's resistance to Asian faculty recruitment and community participation was significant. Precipitating the conflict was the failure of the School of Social Welfare to hire an Asian American curriculum specialist.

NIMH had awarded the training grant to the School of Social Welfare at University B in the early 1970s. The Asian Student Caucus at that school increasingly pressed for Asian faculty recruitment, specifically of the Asian American specialist to develop regular curriculum courses on Asian communities.

In April 1973, the dean of the School of Social Welfare sent a letter to the Council of Social Work Education (CSWE) stating that the school would give "highest priority" to hiring an Asian American. The school at that time was under CSWE investigation for violating accreditation standards. It was also in the process of preparing a new MSW grant request to submit to NIMH that would include possible Asian projects with "appropriate liaison with the Asian [Student] Caucus." In February 1974, the dean was no longer honoring the commitment made in the CSWE memorandum to hire an Asian American. The Asian Student Caucus responded by filing an administrative complaint against the school to NIMH. Milton Wittman, chief of the Social Work Education Branch of NIMH, reassured the Asian Student Caucus that the school's proposal would not be funded in the form in which it was written.

Since the training project at University A was about to enter its last funding year, a joint effort was initiated by members of the University A Training Project, the Asian Student Caucus of University B, and the Asian Coalition on Social Work Training to develop a metropolitan area training center.

The Organization, Objectives, and Basic Assumptions of the Training Center

A proposal was submitted by an ad hoc group to NIMH to establish a community-based training center in the coastal region in collaboration with Asian American human service organizations and various schools of social work and community colleges in the metropolitan area. The purpose of the project was twofold: (1) to help the communities involved create a cohesive network of human services that would function cooperatively in their approach to community mental health, and (2) to become an important source of mental health professionals for the Asian American communities in the target area.

The training center was to be located centrally in an Asian American community. It would house the staff and those students involved in legislative and social research. Asian American human service agencies that directly served the Asian American population were to provide the field instruction. Students from two schools of social work at the master's and bachelor's levels, as well as community college students who specialized in human services at the associate in arts level, were to be recruited as stipend trainees in the center. Pacific and Asian communities initially included were Chinese, Japanese, Pilipino, Korean, Samoan, Guamanian, and Hawaiian. Later, Indochinese (Vietnamese, Cambodian, and Laotian) communities were added as part of the target group.

Soon after funding from NIMH was approved, meetings to set up the organizational structure of the center were held. However, it was not until the second year after the establishment of the center that a formal structure and bylaws were adopted by its council. Figure 1 depicts the organizational structure of the center. The composition of membership, duties, and committee structure of the council were written into the bylaws adopted on September 2, 1976, and amended on January 6, 1977 (see Appendix 1).

The objectives of the training center's council were:

1. To organize and sustain a continuing program of education in the field for Pacific/Asian American students through the development of community-based training centers.

2. To recruit and financially support Pacific/Asian American students in social work fields and to familiarize these students with the similarities and differences among various Pacific/Asian communities.

3. To compile and make available information useful to Pacific/Asian communities in the coastal area.

4. To identify and support legislation at the federal, state, and local levels that would improve the social conditions of the Pacific/Asian communities in the coastal area.

5. To develop linkages between Asian American and Pacific Islander communities and educational institutions for their mutual benefit.

The staff of the center consisted of the director, an administrative assistant, several field coordinators, additional staff obtained from CETA funds, and part-time clerical workers. In the fifth year of the project, a curriculum writer and an evaluator were hired.

Ethnic Resource Groups were established to generate more community input and participation in the center. Five such groups were organized by the training center staff: Korean, Pilipino, Samoan, Chinese, and Japanese. The resource groups were composed of social workers, human service practition-

Figure 1. Organizational Structure of the Training Center

1. With five standing committees: Program, Personnel, Student Matters, Finance, and Policy and Procedures.
2. One for each community represented in the training center.

ers, and other concerned individuals who were familiar with service needs in their respective ethnic communities. They were to advise the staff on the development of criteria for selection of stipend recipients from their ethnic groups and of field work sites that offered the best learning potential in their communities.

During the first year of the training center's existence, a series of seminars was offered to the stipend students to complement the social work curricula of the participating educational institutions. These seminars were planned by the training center staff, in cooperation with individuals from the schools and the communities. During the second year, a Curriculum Advisory Group, composed of Pacific/Asian social service practitioners, social work faculty, and training center graduates, was formed to help develop appropriate teaching materials for the seminars.

The training council was the policy-making and monitoring body for the center's programs and staff. Members of the training council were recruited mainly from social service, health, and community organizations as well as from the colleges. The council was broken down into five standing committees:

1. The Program Committee was responsible for the creation and evaluation of programs.
2. The Personnel Committee formulated personnel policies, reviewed applicants for jobs, and evaluated staff.
3. The Student Matters Committee formulated the student selection and grievance policies and investigated, solicited, and promoted matters related to student welfare.
4. The Finance Committee formulated the finance policies and budget.
5. The Policy/Procedures Committee formulated, reviewed, and revised all policies and procedures not covered by other standing committees, and conducted the nomination and election of officers.

Since the objectives of the training center were broad, it was decided that each year of the funding period should have a particular program emphasis. The following five-year plan was adopted:

Year 1: Development

- Student emphasis: identify and organize Asian American students, paying particular attention to special groups; that is, emergent communities, such as Samoans, Koreans, and Hawaiians.
- Training center emphasis: establish a program model for the training center, including administrative procedures, staff and council roles and functions, policy-making procedures, etc.

Year 2: Community emphasis

- Identify those elements of social work practice that are most appropriate for each Asian American community.
- Develop standards for social service in each Asian American community.
- Begin to implement these standards in training center programs, with the understanding that the standards remain flexible and subject to revision.

Year 3: School emphasis

- Identify different approaches, opinions, and resources in the schools and determine how these might best be utilized for the benefit of Asian American communities.
- Help communities use these resources.

Year 4: Social work model emphasis

- Develop a model of social work that will train people to provide useful social services to Asian American communities.

Year 5: School-community linkages emphasis

- Encourage, facilitate, and consolidate direct communication between the schools and the various Asian American communities.

In the proposal for the establishment of the training center submitted to NIMH, the problems of community mental health were regarded as correlates of systemic and structural defects in the nation's political and economic institutions. The proposal rejected the notion that mental health problems were primarily attributable to life style, dysfunctional family patterns, or individual maladjustment. This assumption about the nature and causes of mental health problems was consistent with the minority perspective in community mental health which had developed in the late 1960s and 1970s.

The proposal emphasized that mental illness was a reflection of existing social problems which created mental stress and that the community should be allowed to define mental illness as well as to decide upon treatment solutions. The control function of social work was rejected, and the freedom of communities and individuals to make choices in training, research, and service delivery was reaffirmed.

Parallel Developments in Training, Research, and Service Delivery in the 1970s

Since the early 1970s, there have been a number of parallel developments in Asian American community mental health in training, research, and service delivery. To provide manpower training, NIMH funded two other centers, located in Los Angeles and Sacramento. These three centers, together with

the Asian American Mental Health Research Center, represented a major portion of NIMH's support for Asian American community mental health training and research.

The Los Angeles center, which was founded in 1972, used the East Los Angeles Chicano Education Training and Research Organization (El Centro) and its counterpart in Houston, Texas, as beginning models. The objectives of this center were (Chikahisa et al. 1976; Kushida et al. 1976):

1. To produce Asian social work manpower: practitioners, faculty, administrators, and leaders in national organizations.

2. To identify the new and old social work methods that were most effective in providing individual, family, group, and community services for Asian Americans.

3. To locate a base of operations for Asian social work where schools of social work and service agencies could interact.

4. To provide schools and agencies with the information needed to improve service delivery to Asian Americans.

These objectives were similar to those of the Coastal Community Mental Health Training Center as defined in its council's bylaws. However, the coastal training center included other objectives:

1. To identify and support legislation at the federal, state, and local levels that would improve the social conditions of the Pacific/Asian communities in the coastal area,

2. To develop linkages between Asian American and Pacific Islanders communities.

Organizationally, the Los Angeles center was also very similar to the coastal training center. It had a community-based organization (Special Service for Groups) as its fiscal agent, an advisory board which had no decision-making power, and a professional staff. Like the coastal training center, the Los Angeles center accepted MSW, BSW, and AA social work students, using similar selection criteria. Its field training programs and ethnic seminar/workshops appeared to be replicas of the coastal training center's. In addition, a curriculum model for Asian American social work that was based on the coastal training center's program and experience was prepared by the Los Angeles center (Kushida et al. 1976).

The Sacramento center was established in July 1975. In objectives and organizational structure it was similar to the other two centers except that it explicitly included the training of social workers for both urban and rural Asian communities. It was also closely affiliated with one rather than several social work programs, the one at Sacramento State University. The fact that the Sacramento training program deliberately concentrated on community organizing as a field of practice also distinguished it from the Los Angeles and

coastal centers, which were more diversified in fields of practice.

During its second year of operation, the Sacramento center conducted a program evaluation. Although an evaluation instrument was constructed, no quantitative data were collected. Nevertheless, some of the conclusions reached in that evaluation (Lum n.d.) are similar to our findings about the coastal training center as reported in later chapters.

In 1975, a national research center was established, partly as a response to one of the recommendations of the 1972 Asian American Mental Health Conference. Originally, the Asian American Mental Health Research Center was located at the University of California, San Diego, in La Jolla. Funded by an initial grant from NIMH, it was structured to meet six major objectives (Liu and Yamada 1976: 136):

1. To initiate and facilitate preliminary studies.
2. To develop training facilities for researchers and scholars.
3. To coordinate research efforts.
4. To provide technical assistance to Asian American communities.
5. To establish a data resource bank on Asians in America.
6. To seek continual funding for research and development.

Later, the center moved to the University of Illinois at Chicago and was renamed the Pacific/Asian American Mental Health Research Center (P/AAMHRC) to reflect its expanded constituency. The establishment of the research center was preceded by the development of the National Coalition of Asian Americans and Pacific Island Peoples for Human Services and Action, which later became the Pacific/Asian Coalition (PAC) (Liu and Yamada 1976:137). PAC and AASW were the two major forces which shaped P/AAMHRC. Like the other centers, P/AAMHRC had a community advisory board, in this case a national one, but P/AAMHRC concentrated on relevant, problem-oriented, and applicable research activities (Liu and Yamada 1976:138).

In the 1970s, a variety of alternative service programs addressed to the needs and problems of individual Asian communities was established (Murase 1978:45). Murase (1978:46) identified the following determinants of effective service delivery:

1. Location of delivery site within the community itself, so that it is immediately visible, accessible, and integrated into the community.

2. Involvement of a broad cross-section of the community in decision making through a representative policy-making board.

3. Employment of bilingual and bicultural staff, including paraprofessionals and other intermediaries from within the community.

4. Utilization of indigenous formal and informal community care/support systems, such as churches, family associations, hometown clubs, fraternal

clubs, credit associations, and community caretakers.

5. Development of culturally relevant intervention methods.

Murase (1978:47-48) also noted that existing services must be integrated into a coherent service delivery system geared to the specific needs of Asian Americans and cutting across agency, institutional, or other boundaries. Since 1978, Murase and his colleagues, in association with the Pacific Asian Coalition, have undertaken a major national research study on mental health services for Pacific/Asian Americans. The findings of this research (Yoshioka, Tashima, and Chew 1981; Murase 1981) again underscored the importance of developing coherent service delivery systems which integrate both physical and mental health services.

Summary

The Coastal Community Mental Health Training Center was one of the products of the nationwide response of Pacific/Asian Americans to the community mental health movement of the late 1960s and the 1970s. This movement drew its inspiration from the social changes occurring in Pacific/Asian American communities at that time. The political climate of these communities was shifting from noninvolvement to active involvement. A whole new generation of community activists had come of age in the late 1960s. Community mental health was, for them, one of the many issues demanding attention and action. By defining community mental health in a broad way, activists were able to coalesce and demand a national response from the federal government—specifically from NIMH.

The coastal training center shared many characteristics with other training centers, research projects, and service programs established in the late 1960s and 1970s. They tended to be community-based. They were usually critical of established approaches to mental health and advocated the development of new approaches that would take cultural factors into account. At least in the beginning, they were inclined to be aligned with the social movement. In that respect, the issues of community mental health were not defined in a narrow way but were seen to be connected with other social, economic, and political issues in Pacific/Asian communities.

Notes

1. The term Pacific/Asian American came into use in the mid-1970s, before which the term Asian American was frequently used. Other synonyms include Asian/Pacific Islander, Asian and Pacific Americans, and variants of these. In this volume the terms are used interchangeably, the one being used at any time being dependent upon the context.

3

An Evaluation of the Training Center: Methodology

Community Mental Health Evaluation

In recent years, evaluation has become a very significant part of community mental health training and services. There are both external and internal demands for evaluation. As mental health needs have expanded, resources have leveled off and even receded due to inflation, recession, and economic conservatism in the political arena (Coursey 1977:1). During a period of economic retrenchment, funding agencies and the communities in which mental health programs are located are much more concerned with accountability. The Community Mental Health Center Amendments of 1975 (Public Law 94-63) authorized up to 2 percent of program funds for technical assistance in areas such as evaluation. Training and service program administrators as well as community boards are also increasingly turning to evaluation as an integral part of overall program planning.

As a result of the attention given to evaluation in recent years, methods have become much more sophisticated and diversified. In the first place, evaluators have become more knowledgeable about methods derived from both early and recent work of social and behavioral scientists. For example, the implications of the early work of Mayo (1933) and Festinger and Kelley (1951) on social program evaluation have been recognized in mental health literature. Since the 1960s, the federal government has also published a sizeable body of literature on the evaluation of mental health programs (see, for example, Davidoff, Guttentag, and Offutt 1977; Landsberg et al. 1979). Finally, innovative work in experimental and quasi-experimental designs (Campbell and Stanley 1966) as well as survey designs (Glock 1967; Lazarsfeld, Sewell, and Wilensky 1967; Suchman 1967) have been incorporated into mental health evaluation studies.

Some Basic Problems in the Evaluation of Community Mental Health Training

The evaluators of minority community mental health training programs shared some basic problems generally faced by all social evaluators. First of all, there are limitations in the methodological rigor of evaluation designs which are beyond the control of the evaluators. Quite often, evaluators are called upon at the end or at transition points of a training program. An evaluation design might have been written into the original funding proposal in rather vague and general terms, but an ongoing evaluation process is not necessarily developed once the program is funded. It is only when the program is near the end of its funding period, or at the point when refunding is sought, that an expert is brought in to do an evaluation.

In the case of the Coastal Community Mental Health Training Center, aside from one descriptive evaluation of the center during the third year of funding, only unsystematic evaluations were conducted sporadically on selected aspects of the program. For example, after the ethnic seminar sessions, students were asked to evaluate their content and presentation. However, the resulting evaluation forms were not statistically analyzed properly.

Beyond such sporadic evaluations of selected programs, there was no ongoing data collection based on sound evaluation methodology. In fact, the lack of systematic data collection for evaluation purposes was only a part of a larger administrative problem which plagued the training center, that being the failure to develop a management information system over the course of the five years of its existence. Recent advances in the management of community mental health training and services (Cooper 1973; Wilder and Miller 1973; Crawford, Morgan, and Gianturco 1974) had no impact on the training center and its program.

In addition, although broad goals were set forth in the funding proposal, specific goals and objectives of the training program were not clearly defined, thus making it difficult to assess achievements. (In many respects, this lack of specificity was an advantage: it allowed the community group which submitted the proposal more room in adjusting to conflicting community interests and in moving toward specific goals more freely at a later stage.)

For example, political advocacy on mental health and on broader community issues was considered an important goal of the program, even though this objective had to be set against a continuously changing political and economic environment. Yet, a lack of long-range objectives on political advocacy made it impossible to evaluate this part of the program. Political advocacy in the form of legislative goals ought to have been determined from the outset.

Because organizational goals and objectives were not clearly defined and a management information system was never developed, the use of "management-by-objectives" (Porter 1977: 93-103) as a method for evaluating the program was not possible.

Another basic difficulty was that there were many potential sources of antagonism between the evaluator and those who were being evaluated. The program administrators, staff, community boards, and others who had been associated with the center might have felt threatened by a critical evaluation for many reasons. There was the question of personal professional reputation. Beyond this, there was a feeling that a critical evaluation of the center might damage the chances of those associated with it to gain funding for other community programs. This was an important consideration because many individuals who were involved with the center were also connected with a variety of other community programs, policy boards, and voluntary organizations. In fact, a chart tracing the organizational affiliations of the people associated with the center would show an extensive network of community organizations.

Since the coastal training center was connected to so many other community programs in mental health, physical health, and human services, there was pressure on the evaluator not to be overly critical. A critical evaluation of the training program might, by association, reflect negatively upon the other programs.

The Role of the Evaluator

In an evaluation study, it is important to determine from the outset the relationship between the organization and the individuals involved in its evaluation.[1] When, as in formative evaluation, the main purpose is to provide feedback to agency decision makers, the evaluator usually reports directly to the executive council or the administrators of the agency. On the other hand, in summative evaluation, the main purpose is outcome assessment so the evaluator is usually responsible to the external funding agency.[2]

The evaluation undertaken in this study was basically summative. The training center was nearly at the end of the five-year funding period. Essentially, the evaluation was a means of summing up the experience of the training center and an opportunity to draw information from that experience.

Prior to hiring the evaluator, three policy options were considered on the administrative relationship that was to obtain between the evaluator (and the evaluation staff) and the training center:

1. That of the evaluator as a staff member administratively responsible to the center director.

2. That of the evaluator as a staff member administratively responsible to the program committee of the Training Center Council.

3. That of the evaluator as an outside consultant who was essentially contracted to do the evalulation for the funding agency (NIMH).

The second option was eventually chosen. With that decision, certain ongoing frictions between the evaluator and the program committee were inevitable. In retrospect, it would seem that, under the circumstances, the third option might have been preferable because the evaluator, as a relatively neutral party, would not have been tied to the ongoing differences and conflicts of the center. However, my experience in conducting program evaluations convinces me that some manifest or latent conflicts in the evaluation situation are unavoidable. In spite of some frictions and confrontation, an overall climate of cooperation characterized the relationship between the evaluator and the different subgroups which constituted the center: the staff, the council, stipend students, etc. Moreover, flexible resource allocations and staff assistance greatly facilitated the evaluation. Since the evaluator had taken on the assignment partially as a community service, considerably more time was spent on the evaluation study than was alloted in the preliminary projections.

The Evaluation Staff

The evaluation staff was composed mainly of training center students. Their employment in this research and evaluation project was basically a sound idea in that it provided them with some training in research. However, two problems related to time limitations were encountered. First, the evaluation was to be completed within a short time period, making it necessary to design the evaluation instrument, collect data through interviews and questionnaires, and process the results quickly. While the students who worked on the project received exposure to instrument construction and some aspects of data reduction, by and large their training was unsystematic. Also, they did not participate in the processing and analysis of the data or in the report writing. Secondly, all the students except one were already working full-time elsewhere, which made it difficult to arrange a common time schedule for this project. Some delays in processing the questionnaires and transcribing interview tapes were consequently experienced.

Construction of Evaluation Instruments

The process of constructing the evaluation instruments followed the typical steps of research:

1. Reviewing funding proposals, historical documents on the development of the center, newsletters, and official files of the center.
2. Reviewing evaluations commissioned by the council, especially the third-year evaluation report.
3. Reviewing self-monitoring evaluations undertaken by the staff, including the annual questionnaire survey of student satisfaction with the training center and the student evaluation of the ethnic seminars.
4. Conducting exploratory interviews with five key people associated with the center, past or present.
5. Reviewing evaluations conducted on other programs which might be useful in establishing some standards for the training center evaluation.
6. Reviewing research literature on community mental health, especially in regard to minority training.
7. Locating baseline data for external comparisons, including the survey of MSW graduates of University A and University B.
8. Constructing the intensive interview schedule.
9. Constructing the standardized student questionnaire and program questionnaire.

The process moved from qualitative steps to the final quantitative instrument construction. The results of the qualitative activities (historical documentation, intensive interviews, etc.) proved to be valuable, perhaps even more valuable than the statistical data from the two questionnaire surveys. On the whole, the process of instrument construction was carried out systematically and rigorously. One area of weakness may have been the inability of the evaluator, due to insufficient time, to visit all the agencies and programs where students were placed.

Evaluation Standards

A lack of clear-cut definitions of objectives and goals on the one hand and a paucity of data on similar community mental health training centers (such as the Los Angeles Center) on the other made it difficult to do standardized statistical comparisons of the strengths and weaknesses of centers.

While it was not possible to obtain comparable data from other training programs for external comparisons, it was possible to maintain methodological rigor in this evaluation by employing the following procedures:

1. A pilot study was conducted in order to gain a better understanding of the history of the coastal training program and the issues that it had faced since the founding of the program. In this study, lengthy, exploratory interviews were conducted with five people who had been actively involved with the training center from its inception. Also, all the documents and records of

the training center, including the sporadic evaluations which were conducted previously, were examined.

2. On the basis of the pilot study, three different instruments were constructed for the evaluation: the intensive interview schedule; the questionnaire survey of stipend students; and the questionnaire survey of staff members, council members, and field supervisors. The use of multiple sources of data, both quantitative and qualitative, provided a deeper understanding of the training center experience. It was possible also to point out differences in opinions and conflicts between different individuals and groups who were associated with the center.

3. On the basis of the quantitative data generated from the two sample surveys, comparisons were made between different subgroups vis-a-vis their opinions about the strengths and weaknesses of the training center. The items used in the questionnaires were pretested, and standards for the construction of questionnaire items were carefully adhered to.

4. After the evaluation, several meetings were held with groups and individuals involved in the training center to go over the evaluation report. The main objective of these meetings was to ensure that the conclusions were objective. Although there were disagreements about particular conclusions, the methods used to arrive at the conclusions were objective. It was also important to present the different views about the training experience from the people who were involved in it in different capacities. No effort was made to develop a "forced" consensus among the participants when there was, in fact, substantial divergence in opinions. The overall evaluation procedure is depicted in Figure 2.

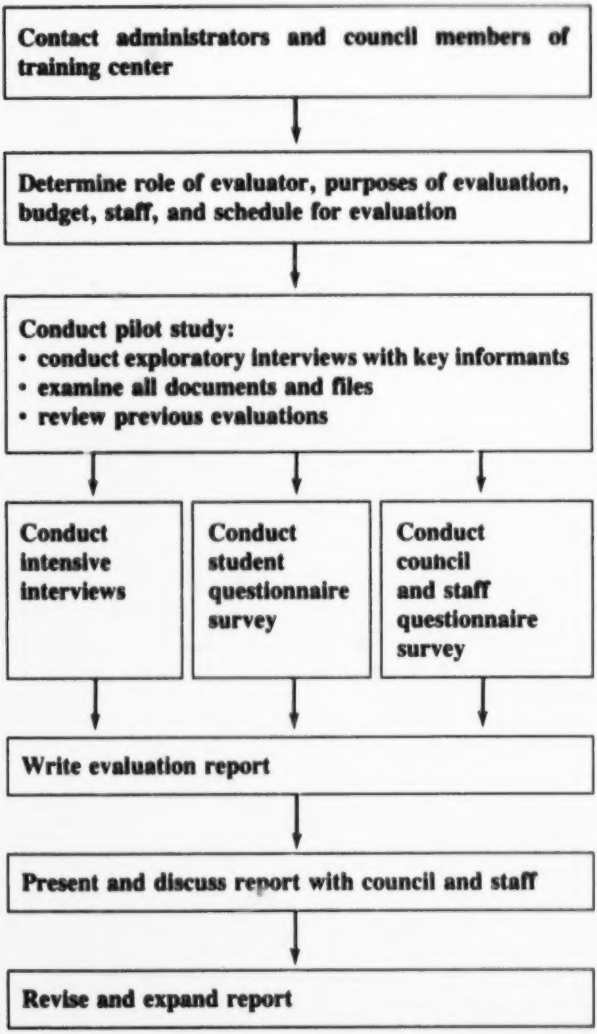
The Intensive Interviews

Before conducting the intensive interviews, five lengthy exploratory interviews were completed to identify the basic issues and concerns in this evaluation of the training center. From these exploratory interviews, a nineteen-question intensive interview schedule was constructed (see Appendix 2). As explained in its instructions, the main purpose of the schedule was to gather in-depth information on various aspects of the performance of the center.

The second purpose of the intensive interview was to explore a number of areas that were not well understood. "Probes" were made when a respondent wished to or was able to elaborate upon a particular question at greater length.

Most respondents were chosen because they could provide in-depth information about the entire history, or some significant phase, of the development of the training center. An effort was also made to ensure equal representation

Figure 2. Schematic Diagram of the Evaluation Procedure


Contact administrators and council members of training center
Determine role of evaluator, purposes of evaluation, budget, staff, and schedule for evaluation
Conduct pilot study:
• conduct exploratory interviews with key informants
• examine all documents and files
• review previous evaluations
Conduct intensive interviews
Conduct student questionnaire survey
Conduct council and staff questionnaire survey
Write evaluation report
Present and discuss report with council and staff
Revise and expand report

of nationalities, sexes, and of council members, supervisors, and former students. In some cases, choices were made randomly among several people whose experience with the training center appeared to be comparable. The intensive interviews lasted from one to five hours, with a mean of 3.2 hours. A number of the interviews were taped with the consent of the respondents and were later transcribed without recording their names. In this way, strict confidentiality was maintained.

The intensive interviews provided in-depth data on the history and development of the training center, the issues and conflicts, and the people who contributed to its strengths as well as its weaknesses. In addition, sufficient understanding was acquired about the students, council members, and field work supervisors of the training center to construct the two standardized survey questionnaires. No separate section on the intensive interviews was written. Instead, intensive interview materials, like the open-ended responses in the questionnaires, were used to illustrate statistical findings, to add depth to the statistical analysis, and to explore controversial as well as ambiguous issues.

The Student Survey

The student survey questionnaire (Appendix 3) was mailed to all former stipend students. The follow-up procedure, which was similar to that used in the program survey (see below), yielded a relatively high adjusted response rate of 74 percent. A comparison of selected characteristics (see Table 3) shows that the sample is highly representative of the population in terms of ethnicity, with the exception of an underrepresentation of the Samoan group. The sex composition of the sample is also highly representative. Finally, in terms of schools in which the students were enrolled and their objectives, it appears that the sample is representative if the "no information" group is omitted from the population.

The Survey of Council, Staff, and Field Supervisors

The program survey questionnaire (Appendix 4) was mailed to former and current staff and council members as well as field supervisors. Ten days after the initial mailings, a telephone follow-up was made to those who had not returned the questionnaire. Two more follow-ups were made after the first, at ten-day intervals. Because the survey was conducted in July and August, a number of people were on vacation or otherwise not available. The remaining nonrespondents were not systematically studied, but it appeared that some were concerned about confidentiality. Others were intensive interviewees

Table 3
Student Survey: Percent Distribution of Selected Characteristics of the Population and the Sample

Selected Characteristics	Population (N = 69) Percent	Sample (N = 39) Percent
Ethnicity		
Chinese	29	31
Pilipino	19	31
Samoan	16	3
Japanese	15	18
Korean	12	10
Vietnamese	4	5
Cambodian	1	3
Thai	0	0
Other	1	0
No information	3	0
Sex		
Male	46	44
Female	49	51
No information	5	5
School enrolled in		
University A	39	54
University B	28	31
Community College A	0	3
Community College B	0	0
Community College C	13	13
No information	20	0
Degree working toward		
MSW	48	54
BA or BSW	19	31
AA	13	10
Other	0	0
No information	20	5

who felt that they had already made an adequate presentation of their views.

Based on the effort expended to solicit more response, the adjusted response rate (56 percent) is somewhat disappointing, though adequate given the sample size. Fortunately, a comparison of selected characteristics (ethnicity and sex; see Table 4) shows that the sample is highly representative of the population.

The Purposes of This Evaluation Study

Evaluations can have multiple applications, providing a basis for fiscal accounting, feedback for improvement in staff performance, dissemination of knowledge, and theory building (Brooks 1965). In the case of the evaluation of the Coastal Community Mental Health Training Center, some feedback was given to the staff concerning their performance and some information about the cost-effectiveness of the training program was obtained from the

Table 4
Program Survey: Percent Distribution of Selected Characteristics of the Population and the Sample

Selected Characteristics	Population (N = 87)	Sample (N = 40)
	Percent	Percent
Ethnicity		
Chinese	33	35
Pilipino	20	10
Japanese	17	20
Korean	5	3
Vietnamese	3	3
Cambodian	1	3
Samoan	1	3
Thai	0	0
Other	20	20
No information	0	6
Sex		
Male	51	45
Female	49	48
No information	0	7

intensive interviews and from the open-ended responses to the questionnaire surveys. However, fiscal accounting and feedback were definitely not the main functions of the evaluation. As a matter of fact, when the evaluation was done, the training program was destined to be terminated.

Under these circumstances, it seemed more important to determine if the basic theoretical assumptions of the training program were valid or not and to disseminate the results of this evaluation to professionals and to the community. When a very substantial amount of public money has been expended on a social experiment, whether it involves direct services, training, or research, it is imperative that our knowledge about the successes and failures and strengths and weaknesses of the experiment be conveyed to a wide audience. This is consistent with the spirit of the community mental health movement, which, above all, strived to involve both concerned citizens and professionals in the program's planning and decision making.

In Chapter 2 of this book, the development of the Coastal Community Mental Health Training Center was analyzed historically. That analysis also presented what the original advocates of the center considered to be the theoretical assumptions and main purposes of the program, even though assumptions and purposes were not very clearly formulated. The intensive interviews and the questionnaire surveys were designed to gather both in-depth and quantitative data about the successes and failures of the training program. Participants were asked whether the main purposes of the program were achieved and whether the theoretical assumptions were, indeed, validated empirically. The next two chapters present the results of the questionnaire surveys and intensive interviews. In Chapter 6, general conclusions and the implications and significance of the training program are made.

Notes

1. Some of the problems and issues in the relationship between the evaluator and the organization to be evaluated are discussed by Gurel (1975), Walton (1969), and Weinstein (1972).

2. For the distinction between formative and summative evaluation, see Isaac and Michael (1981).

4

The Students' Training Experience: The Correlates of Satisfaction and Impact on Professional Career

In this chapter, the results of the survey of former Coastal Community Mental Health Training Center students are reported. Their ethnicity, age, community experience, academic qualifications, and other characteristics are examined to determine whether the avowed recruitment policies of the training center were implemented. The rate of continuation of students after graduation in the field of social work and community mental health as well as in Asian American community agencies is ascertained, and the impact of the students' training on their current professional careers is examined.

Student respondents in this survey were asked a number of questions regarding their satisfaction with the following dimensions of their training experience: (1) field coordination and supervision, (2) the social work curriculum at their schools, (3) the training center seminars, and (4) field placements. Their level of satisfaction with each of these aspects of the training experience is correlated with their overall rating of the professional preparation received.

The results of the one-way analysis of variance tests on degree of satisfaction among different subgroups of respondents are also reported. Findings from the sample survey are supported by materials from intensive interviews with selected students, and the implications of the student survey findings for community mental health training are discussed.

A Demographic Profile of the Student Population

In the spring of 1979, questionnaires were mailed to former stipend students of the center. (The questionnaire is reproduced in Appendix 3). The adjusted response rate was 74 percent. Four parameters on their background were computed: sex, age, ethnicity, and academic goals.

Results (presented earlier in Table 3) showed that there were slightly fewer males than females. Eighty-seven percent were between 21 and 30 years of age. In terms of ethnic background, 63 percent were either Chinese, Japanese, or Pilipino. Most of the remaining were Korean or Samoan,

leaving a minority from Southeast Asian and other Pacific/Asian American groups.

The stipend students were recruited from the Associate of Arts (AA) programs in human services at several community colleges, and BA, BSW and MSW programs at two universities. The largest percentage of these students was enrolled at University A; the next largest at University B. Leaving out the cases for which there is no information, 60 percent were working for the MSW degree, 24 percent for the BA or BSW degree, and 16 percent for the AA degree. This shows clearly that the emphasis of the center was on MSW professional training.

The income distribution of former students in 1979 is shown in Table 5. Their mean annual income was $11,452.

Recruitment Policies and Practice

Relying on sample survey statistics, evaluators found that 64 percent of the students were born in this country. Of those who were immigrants, 90 percent had been here for more than six years. This reveals a weakness in the center's recruitment policies and practice. Inadequate recruitment of recent immigrants had led to an underrepresentation of bilingual students. Only 36 percent of the students had some bilingual skills.

In addition to bilingual-bicultural representation, the center's recruitment

Table 5
Percent Distribution of Students by Income Level at Time of Survey, 1979

Annual Income ($)	Percent of Students
0–7,999	19
8,000–8,999	10
9,000–9,999	6
10,000–11,999	10
12,000–13,999	26
14,000–15,999	13
16,000–17,999	10
18,000 and over	6
Total	100

criteria called for a proper mix of community experience and academic performance. Table 6 shows that about two-thirds of the students had had two or more years of working or voluntary experience in Asian American communities. The survey also revealed that their mean grade point average at the time of application was 3.00.

While there was a highly positive correlation between prior working experience and voluntary experience in Asian American communities (r = .70, p < .0001), both community experience variables were negatively correlated to a small, but nonsignificant, extent with grade point average (r = -.19, p = .36 and r = -.05, p = .79, respectively). The stipend students with more community experience tended to have lower grade point averages, which suggests that a trade-off between academic performance and community experience was used in student selection.

It should be noted that there were differences in the recruitment practices for each ethnic group. In the intensive interviews, one respondent remarked that:

> each ethnic group defined its own criteria for student recruitment. It might have been beneficial and consistent if the training center had its own minimum guidelines from a needs assessment to verify what kinds of students were needed in each community.

Table 6
Percent Distribution of Students by Prior Experience in Asian American Communities

"At the time when you applied for a student stipend, how much working and voluntary experience did you have in Asian American communities?"

	Percent of Students	
	Working Experience	Voluntary Experience
0–1 years	39	38
2–3 years	32	38
4–5 years	11	11
6 years or more	18	13
Total	100	100

Another respondent said:

> In the student selection process, even though different procedures existed for different ethnic groups, specific ethnic groups felt that the process was unfair and students were selected out of favoritism. The training center was not consistent in the student selection process throughout the four years and it wasn't until year four that it was finally agreed upon by staff and council members that policies be set in year five.

Retention of Former Students in Social Work and in Asian American Communities

Most former stipend students had remained in the social work profession or were acquiring more training in that profession (71 percent). At the time of the interviews, 63 percent of the respondents had at least some contact with Asian clients while 37 percent had little or none. Since an explicit goal of the center was to train professionals who would serve Asian American communities, 37 percent represented a substantial personnel drain. During their training, 72 percent of the first placements of students had been in Asian American agencies. The corresponding figure for the second placement was 50 percent, yet only 33 percent were currently working in Asian American agencies. According to one respondent, "The center had no follow-up after we graduated; they didn't give us much help in finding jobs in the Asian communities, so I had to find a job outside in order to survive."

An examination of Pearsonian correlation coefficients revealed that students who received stipends in earlier years were less likely to be working with Asian American agencies or clients in their current jobs ($r = -.29$) than those who had received them in later years. This indicates that, as the years elapsed, fewer and fewer of the professionals trained through the center were retained within Asian American communities. In addition, former students who were working in Asian American agencies with Asian clients had lower incomes than those who were not ($r = -.31$). Were Asian communities able to provide professional and income opportunities for stipend students? Without an assessment of their mental health or social service manpower needs, we cannot venture a guess.

It is possible that the theory of the dual or split labor market (Bonacich 1972; 1976)—which argues, among other things, that jobs with equal skill and experience requirements pay less in minority markets—also applies to the social service positions in Asian communities (Young 1977).

Statistical breakdowns on the fields of practice indicated that former trainees were widely distributed among thirteen fields, as shown in Table 7.

In a real sense, the community mental health training center had functioned as a general community social work training center. The respondents were much less diversified in their current jobs, however, with 64 percent engaging in direct service. Significantly, few or no respondents were concentrating on staff development and training, research and proposal writing, consultation, other indirect services, or macro social work. This suggested a need for training and job development in the areas of indirect services in Asian American communities.

The Relationship between Students' Training and Their Current Professional Careers

Was the low level of current professional involvement in indirect services a consequence of insufficient training or a paucity of job opportunities? The data can only provide the answer to the first part of this question. The students, on the average, were exposed to 3.1 (SD = 2.03) fields of practice and 7.3 (SD = 4.27) types of activities in their training (for the classifications,

Table 7
Percent Distribution of Students by Current Major Field of Practice

	Percentage of Students
Developmentally disabled	13
Services to children	13
Research	12
Medical social work	9
Administration	7
Community organizations and social planning	7
Corrections	7
Mental illness	7
Schools of social work	7
Services to aged	7
Community mental health	3
Public welfare	3
Services to families	3
Other fields	2
Total	100

see Appendix 3, Items 11 and 12). There was, however, wide variation in both the number of fields of practice and types of activities. A logical guess is that students who were placed in alternative service organizations in the communities were exposed to many fields and activities, whereas those placed in more traditional professional agencies were exposed to fewer but received more specialized training.

The focal activity in the field placement of each student was determined by the following question: "Which of the major activities would you rank as the most time-consuming aspect of your field placement?" The breakdown of the activities was 70 percent direct service to 30 percent indirect practice. Significantly, few or no respondents listed staff development and training, research and proposal writing, consultation, client advocacy, or other types of indirect practice as their major activity in the field. The lack of training in indirect service might have contributed to the low level of current professional involvement in these areas.

This deficiency in the training for indirect service was also noted in a student survey conducted in the 1976-77 academic year. In that questionnaire, most respondents indicated that the skills they learned were limited to those needed in direct service roles—such as conducting casework, interviews, and counseling and understanding interpersonal relations and individual, family, and community needs and resources. There was relatively little information about learning experiences in program administration or management, research, program planning, institutional or policy analysis, or the relationship of agency programs to larger social issues.

It should be noted, on the other hand, that the distribution of students with field placements in indirect service (30 percent) and direct service (70 percent) was very comparable to the distribution of method specialization discovered in a 1977 national survey of social service personnel. In that study, the method specializations of about three-fourths of the nation's social workers were found to be in direct services, with about one-fourth in indirect service (Hardcastle and Katz 1979:35). However, a much larger percentage reported that indirect service was the primary practice method used in their current or most recent professional jobs in social work. Among respondents holding a BSW degree, only 58 percent of the regularly employed mentioned direct service as their primary practice method. The percentage for newly employed BSW graduates was 76 percent (Hardcastle and Katz 1979:40), which is roughly comparable to the percentage distribution of training center graduates in direct services (64 percent) and indirect services (36 percent).

The question of the relative needs of Pacific/Asian communities for professionals with direct versus indirect service skills remains unresolved. Findings from current research on mental health service needs in

Pacific/Asian communities, such as the national study conducted by Murase and associates (Yoshioka, Tashima, and Chew 1981), have yet to provide an answer.

Satisfaction with Liaison, Coordination, and Supervision in the Field

There was considerable ambiguity regarding the roles of field liaisons from the schools, the center's field coordinator, and agency field supervisors because the center organized field coordination somewhat differently than more typical programs do. Normally, a social work student is responsible to a school's field liaison person and an agency field supervisor only. The additional involvement of the center's field coordinator complicated this, causing an ambiguity in roles as well as overlaps in function and possible conflicting demands on the students.

The students were mostly satisfied with the center's field coordinator (mean = 1.7, SD = .91) and the agency field supervisor (mean = 1.8, SD = 1.04), but the rating for school field liaison personnel dropped to a mean of 2.7 (SD = 1.45), on a scale from 1 (very satisfied) to 6 (very dissatisfied). One reason for this was that the school field liaison person had more students to supervise than the other field professionals and, hence, less contact with the individual student. A second reason cited by a number of respondents was that the school field coordinator had little knowledge of Asian American community agencies. For example, one respondent said:

> I don't think the fieldwork liaison from my school had much understanding of the kind of work done at a community agency and therefore didn't have much input into my fieldwork experience.

At first glance, the low ratings for the school field liaison persons might seem to be related to the high ratings for the center field coordinator and agency supervisors. However, the data in Table 8 show that there was no significant correlation among the three ratings, thus disproving a cause-and-effect relationship. In other words, the three ratings were independent.

Former students also noted this lack of clarity about the roles of the center's field coordinator, the school's field work liaison, and the agency supervisor in their intensive interviews. Furthermore, students felt that the linkages among the three component institutions (training center, school, and agency) were never clarified in either policy or practice. Little recognition seemed to have been given to the problem of integrating field and classroom learning. Neither the schools nor the training center appeared to have any substantial influence upon the content of students' learning experiences.

The dissatisfaction with school fieldwork coordinators was common to all

five colleges. However, it was not derived from an overall dissatisfaction with the programs in the schools of social work. As Table 9 shows, although there were some variations, students made fairly positive evaluations of the different components of the social work curricula.

The Training Center Seminars

The training center had conducted a student evaluation of the seminars in 1976-77. At that time, students felt that these seminars were useful in sensitizing them to the history and issues of Pacific/Asian communities and the problems faced by Pacific/Asian community agencies. Our survey data confirmed those observations. The mean rating of satisfaction with the seminars was 2.4, on a scale of 1 (most satisfied) to 6 (least satisfied).

In their open-ended responses, students assessed the strengths and weaknesses of the seminars in detail. Generally, these respondents felt that the seminars were useful in providing information about Pacific/Asian peoples and communities but were not different, in most cases, from their classes in ethnic studies. Because the training center had not been able to develop curriculum materials for community mental health training, there was no knowledge base on which the seminars could be built. As one respondent remarked:

> No plan was ever made to develop the seminars. Over the five-year period, there was no growth in content.... The students could have been utilized to do the research to improve the seminars. But that was never done. There was no staff member with enough research and curriculum development experience to get that off the ground. We did not put together a curriculum that was usable. We had pieces here and there.

Table 8
Correlations between Students' Ratings of the Field Personnel

	School Field Liaison		Agency Supervisor	
	r	*p*	*r*	*p*
Center field coordinator	.15	.21	.02	.45
School field liaison person			.12	.28

Note: Pearsonian correlations and probability levels.

There was no commitment on the part of the center to produce on a yearly basis. It was always at the spur of the moment.

In addition, the seminars tended to focus on community and ethnic awareness, Asian American history, and community issues and not on specific direct as well as indirect service skills in community mental health. Because the seminars did not provide unique professional training, there was some question as to whether they should have been offered at all.

Satisfaction with Field Placement

In general, most of the students (79 percent) were satisfied with their field placements. The main reason cited for satisfaction was the opportunity to work with Asian clients or be exposed to problems in Asian American communities. In only a few cases, however, was there explicit mention of high quality professional training.

A significant 21 percent of the respondents answered that they would have preferred a different field placement. Some wanted a more structured setting that would provide systematic training in administration, proposal writing, or

Table 9
Students' Evaluation of Their School's Social Work Curriculum

	Students' Ratings	
	Mean	Standard Deviation
Field instruction in general	1.5	1.04
Practice methods courses in general	1.5	1.04
Electives in social welfare	1.5	.83
Other electives	1.5	.92
Growth and development courses	1.6	1.10
School experience in general	1.8	.86
Classes in general	1.8	.99
Social welfare policies	1.9	1.32
Research	2.0	1.03

Note: Rating is from 1 (very helpful) to 5 (not at all helpful).

therapeutic techniques. Others felt they needed training in mental health service delivery systems. In some field placements, students did not receive any professional social work training at all, and, in fact, social work as a profession was perceived in a negative way. Also, in a number of cases, respondents felt that they should have been placed in a non-Asian as well as an Asian agency. As one respondent stated:

> Being placed in such an agency provides the training and political awareness that Asians need to become familiar with . . . in other words, learning about the struggles and frustrations in trying to help your own people in a non-Asian agency.

Among the students who were dissatisfied with their field placement, most were concerned with the following four variables, ranked according to importance:

1. Did it provide intensive professional training?
2. Did it provide multifaceted professional training?
3. Did it serve Asian clients?
4. Was it located in an Asian American community?

Students were clearly more concerned with receiving high quality professional training than with being placed in Asian American communities.

Table 10
Correlations between Students' Overall Evaluation of Professional Preparation and Specific Aspects of the Training Experience

"How well did your experience at the training center prepare you for professional social work in Asian American communities?"

Specific Aspects of Training Experience	Overall Rating of Professional Preparation	
	r	*p*
Center's field coordinator's performance	.53	.001
Agency supervisor's performance	.02	.448
School liaison person's performance	.34	.030
Seminars	.71	.001

Note: Pearsonian correlations and probability levels.

The intensive interviews revealed a considerable variation both in the amount of supervisory attention students received and in what they were taught. Supervisory attention ranged from none to more than fifteen hours per week. The content of field teaching was vague, suggesting that more attention should have been given to the development of a fieldwork syllabus for each student by field professionals from the center, the school, and the agency. Much of a student's learning experience was limited to the day-to-day operation of the agency. Little or no attention was given to conceptualization, transference of skills, or the integration of general theories with specific practice situations.

The lack of uniformity in supervisory attention and learning content contributed to student dissatisfaction with field placements. It should be noted that there was a great deal of variation in the professional qualifications and experience of the field supervisors. Similarly, the Asian American agencies involved ranged from comprehensive, integrated mental health centers to newly founded alternative community service centers.

The Correlations Between Students' Satisfaction with Overall Training and Specific Aspects of That Experience

In the survey, students were asked: "How well did your experience at the training center prepare you for professional social work in Asian American communities?" Their responses were used as a general indicator of student satisfaction with the center's overall training program and were correlated with their ratings of specific training functions. The results in Table 10 show significant positive correlations between overall satisfaction with the center's training program and student ratings of the center's field coordinator, the school's field liaison person, and the ethnic seminars. However, the correlation between overall rating and rating of agency field supervision is not significant, suggesting that the field training in agencies was not well integrated with the training experiences.

If future training programs were to be developed, it might be preferable for them to be integrated within field settings, rather than separated administratively and professionally. In the Coastal Community Mental Health Training Center, the fieldwork component was separate from the other training center functions. No professional with extensive experience in research and teaching was hired by the center, and professional training was carried out primarily outside the center. Any training function that was conducted directly by the center became, in fact, extracurricular and supplementary.

It should be noted that some students looked upon the center not so much as a training institute as a "support system." One respondent said:

The overall goal of the training center was to develop a support system which could assist in the training of social service workers who would offer relevant services to the various communities. This support system was facilitated in the seminars in which the students shared their experience with others in the social work field. The seminars would help students in broadening their vision of social work and the services that were available.

Other students expected the center to provide even more comprehensive support than described above. They expected counseling and therapeutic services, help with summer job placement and job placement after graduation, help for undergraduate students with their applications to graduate schools, and financial assistance. Their dissatisfaction with the center was based on the fact that these support services were not systematically provided rather than on the quality of the training per se.

Differential Satisfaction with the Training: A Series of One-Way Analysis of Variance Tests

Differential satisfaction with the training among subgroups of respondents was determined by means of one-way analysis of variance tests. The independent variables were:

1. The current level of contact with Asians.
2. The amount of volunteer work in Asian American communities respondents had done at the time of application for stipends.
3. The amount of paid work experience in Asian American communities respondents had had at the time of application for stipends.
4. The grade point average of recipients at the time of application for stipends.
5. The year respondents received stipends.

The dependent variables consisted of five sets of measures of satisfaction with the training:

1. The degree of satisfaction with the fieldwork coordinator of the training center, the fieldwork supervisor of the agency, and the school's fieldwork liaison person (three separate variables).
2. An overall index of satisfaction with fieldwork.
3. The degree of satisfaction with the training center seminars.
4. The degree of satisfaction with the curriculum based on a 9-item index.
5. The degree of satisfaction with the professional preparation for social work provided by the training center.

The level of contacts with Asians which respondents had on the job significantly affected their degree of satisfaction with training center seminars (p =

.04) and with their preparation for social work in Asian communities (p = .05). The respondents who had a high level of on-the-job contacts with Asians were more satisfied with the training center seminars and the overall preparation for social work in Asian American communities provided by the center. Obviously, the seminars, which emphasized history and social issues, were more applicable to the professional needs of respondents who had more contacts with Asians.

To determine the degree of satisfaction with the school curricula, a simple cumulative index was used to calculate the mean score on nine items measuring satisfaction in specific curriculum areas, including field instruction, practice methods, growth and development, welfare policy, research methods, electives in welfare, and other electives. The analysis of variance tests showed that having contact with Asians in a current job did not significantly affect a respondent's degree of satisfaction with the school curriculum. The same independent variable (contact with Asians in a current job) was also not found to be significantly related to the degree of satisfaction with the field experience.

The amount of voluntary experience in Asian American communities students had at the time of application for training center stipends was significantly related to their level of satisfaction with the training seminars. Not surprisingly, students who had voluntary experience in Asian American communities prior to receiving a stipend were significantly more satisfied with the training seminars (p = .05). Students having previous working experience in Asian American communities also gave the training seminars higher ratings, but this was not significant (p = .21). Similarly, students with voluntary or working experience in Asian American communities were more satisfied with the preparation they received for social work in Asian American communities, although once again the results were not significant (p = .32 in both cases). The results suggest that the more prior or current involvement in Asian American communities respondents had, the more satisfied they were with those aspects of the training experience directly related to Asian American communities. Perhaps what could be deduced from these findings is that the training experiences reinforced the sense of commitment to Asian American communities where it already existed but did not lead to greater Asian American community involvement among respondents who were not particularly committed to the communities prior to their sojourns at the center as stipend students.

Variations in satisfaction with the training experience were also examined with respect to the grade point average of students at the time of application for stipends. Grade point average significantly affected student satisfaction with the field experience and with the training seminars. Students with lower

grade point averages were more satisfied with both the field training and the seminars ($p = .02$). These findings support the conclusions derived from intensive interviews. The students with higher levels of academic achievement (as measured by grade point average) felt that the field training was vague and lacking in professional content in the areas of direct intervention, planning, administration, and research. These students saw the seminars as primarily useful in sensitizing them to social issues in Asian American communities.

There was no significant difference in levels of satisfaction for students who received stipends in the first two years and those who received them in the third and fourth years. This is not a surprise. To a large extent, the content and organization of the training experience remained about the same throughout the history of the training center. There was very little incremental growth or significant development in the curriculum or the field program.

The Implications of the Survey Findings on Community Mental Health Training

The Coastal Community Mental Health Training Center was founded at a time when the mental health profession was very much in flux and significant social changes were occurring in Pacific/Asian communities. The very fact that community mental health was regarded as part of a "movement" indicated the profession's openness to change or at least its resistance to institutionalization. In a period when the professional and training boundaries of community mental health were in doubt, minority communities were advocating alternative training programs.

It has been observed (Goldstein 1977:226) that there are two basic principles of planning for training programs:

1. The development of instructional training or training techniques and evaluation models must be based on a careful and thorough needs assessment.

2. The systematic development of any training or change in technique is dependent on thoughtful evaluation, which provides the information necessary to suggest such revisions in techniques.

Unfortunately, the alternative training program implemented at the Coastal Community Mental Health Training Center was not based on a careful and thorough needs assessment. No uniform student recruitment policy was established until the fourth year of the five-year program, and no year-by-year recruitment plan based on community needs was developed. There was no built-in self-evaluation system based on a sound research design (for example, a quasi-experimental design or a management-information approach) which would provide the information needed to suggest revisions in the training

program. Added to this was a lack of clarity regarding the roles of the major facilitators in the training process—the center's field coordinator, the school field liaisons, and the agency field supervisors. The result was considerable dissatisfaction with the training experience among stipend students.

Nevertheless, the survey of stipend students suggested that those who were more involved in Asian American communities prior to their participation in the training center tended to continue their community involvement after the stipend year. If a split labor market in community mental health did exist in Asian communities, this continuing community involvement in spite of fewer opportunities for career and income advancement might be the result of their personal commitment to community welfare.

According to William H. Denham (1982), director of the Division of Manpower and Training Programs of NIMH, in the thirty years of its existence, NIMH's manpower programs have evolved through roughly four stages: (1) the beginning period, 1948-1960; (2) the Camelot Era or period of expansion, 1960-1969; (3) the period of retrenchment or the Ice Age, 1970-1975; and (4) the period of reassessment and redirection, 1975 to the present.

The fourth stage was initiated by the former NIMH director, Dr. Bertram Brown (Denham 1982). One of the assumptions of the new manpower policy which emerged in this period was that the focus of training and education must be relevant to, and derived from, the manpower needs of service agencies (Denham 1982). Although the Coastal Community Mental Health Training Center made a general plan for better community mental health services in Pacific/Asian American communities, it did little in the area of manpower research and development. Denham (1982) observed that:

> the education process in mental health has not been a subject for systematic investigation. By and large what had been offered as educational research and development, such as innovative or demonstration training projects to develop new sources of manpower, does not meet the criteria of systematic generation, testing and replication of knowledge and needed technology on the educational process itself. The training of minorities or the training of nonminorities for serving minority populations is a striking example of an area of educational policy which has been influenced relatively exclusively by political and social justice factors. Policy in this area certainly would be strengthened if it was informed by systematically derived knowledge.

Our investigation of the training center shows the lack of a systematic plan to evaluate and develop the training program. By the time a summative evaluation was done after the fourth year of the five-year program, the opportunities for ongoing program modification and development were already lost.

The training center provides another indication of the need for systematic planning in community mental health training.

5

An Evaluation of the Training Center: Views of the Staff, Council Members, and Field Supervisors

In this chapter, the results of a survey (hereafter referred to as the program survey) of training center staff, council members, and field supervisors are analyzed. Throughout the discussion, statistical results are supplemented with data from intensive interviews. In the program survey, respondents were asked to to what extent the center had achieved its major goals, as well as a number of more specific questions on the satisfaction of students' needs, quality of training, impact on the colleges, relationship with Asian/Pacific Islander communities, quality of staff performance, and quality of the training council's performance. Variations in evaluation ratings for subgroups of respondents were tested by analysis of variance methods. A factor analysis was conducted to determine how many common dimensions of performance evaluation there were.

Selected Demographic and Professional Characteristics of Respondents

Program survey questionnaires were sent to 87 former and current staff, council members, and field supervisors of the training center. The return rate was 46 percent. Seventy-nine percent of the respondents were still working in the social work profession. Half provided services mostly to Asians in their present job, and 47 percent worked in an Asian agency or program. However, a sizeable percentage (37 percent) had relatively little contact with Asian clients (25 percent or less) in their jobs.

When the fields of practice were classified into 13 categories (see Program Evaluation Questionnaire, Appendix 4, no. 15), 42 percent of the respondents mentioned community mental health, mental illness, or community organization as their main field. Direct service to clients was the major on-the-job activity of only 28 percent of the respondents. Thus, this group of respondents was overrepresented by professionals involved in indirect service of various types (community organizing, planning, administration, and so forth). In addition, 62 percent of them were social work supervisors, with a mean of 2.7 years of experience in supervising MSWs or other professionals.

The salary level for professional positions in minority communities tended to be lower than comparable positions outside. Although a significant portion of respondents in the program survey occupied middle- and high-level positions in professional social work, their mean income was only about $16,000, with 43 percent of them having incomes of over $18,000 per annum. This relatively low mean income was probably linked to the existence of a dual social service labor market in Asian/Pacific communities. As described in Chapter 4, a dual market means lower salaries in minority communities (Bonacich 1972, 1976; Young 1977).[1]

Other tabulations showed that the council was largely professional rather than community-based. On the whole, grass-roots community organizations were not well represented on it. Moreover, members participated as individuals rather than as representatives of a community or organization.

The ethnic composition of the staff, council members, and supervisors (presented earlier in Table 4) showed, without question, an overrepresentation of the more established communities (Chinese, Japanese, and Pilipino) and underrepresentation of the newer or emerging communities (Korean, Samoan, and Southeast Asian). The fact that the total U.S. population of Southeast Asians will soon surpass that of some of these established Asian groups makes this issue all the more significant. The underrepresentation of the emerging communities as council members and supervisors of the training center reflects a much larger political issue.

Contrary to the claims of some of its critics, the center was able to establish a relatively stable core of staff, council members, and field supervisors. Although several people important in the development of the center had resigned from the staff or council for reasons such as lack of time or disagreements over politics, the mean number of years of association with the training center was 3.2. There was a substantial core of people who had been associated with the center for 3 to 5 years (59 percent), and therefore a good mix of old and new members among the staff, the council, and the field supervisors.

Did council members have the experience and training to actually formulate policy? Was the staff able to implement the decisions? How adequate was the training offered by the field supervisors? In short, were those involved in the development and operation of the center professionally prepared to advance its objectives and goals? The data from the program survey and the intensive interviews answer these questions.

Did the Center Achieve Its Goals?

First, the goals of the training center were identified by examining the original proposal submitted to and funded by NIMH, together with the annual

progress reports. Although the center's major goals were identified through this process, its specific objectives were never formulated.[2] They might have been had the center developed a program evaluation system, a management-by-objectives approach (Porter 1977), or a goal-attainment approach (Scherman 1977), but since they were not, the evaluations of respondents had to be based on subjective impressions rather than precise criteria.

Table 11 shows the results of these evaluations. Respondents felt that the center was most successful in terms of financial assistance (which was ranked the highest), bilingual/bicultural recruitment, and social support. The center was considered least successful in its training and curriculum development. In fact, out of the four goals which received the poorest ratings from the respondents, three of them were in these areas:

1. Providing training for Asians/Pacific Islanders entering the social work field.
2. Developing training materials and resources on the mental health of Asians/Pacific Islanders.
3. Getting social work schools to set up curriculum relevant to Asians/Pacific Islanders.

Even in the case of the goal of providing community-oriented training, which received a fairly high overall ranking, the standard deviation shows a considerable variation in ratings.

The goals pertaining to advocacy for Asian/Pacific Islanders received mixed ratings. For example, "act as advocate for the needs of Asian/Pacific Islanders" received a high ranking, "get the social work schools to recognize the needs of Asian/Pacific Islander communities" received a medium ranking, and "identify and support legislation affecting Asian/Pacific Islander communities" received a low ranking.

In sum, then, respondents did not think highly of the center's training program although they believed that the center had provided opportunity and support, especially to bilingual/bicultural students. However, the student survey shows that only 36 percent of the students were bilingual.

A goal achievement index was constructed by computing the means of each respondent's ratings, and one-way analyses of variance of these index scores were conducted with selected independent variables. The results indicate that respondents who had longer associations (more than three years) with the center and those who were more active gave significantly lower ratings on the Goal Achievement Index ($p = .03$ and .04, respectively). So did the subgroup of respondents who were employed in an Asian American agency ($p = .02$) or had had more contact with Asians in their jobs ($p = .05$). These statistical findings are borne out by the intensive interviews. Many respondents who had been involved with the center either from its inception or

Table 11
Program Survey: Successfulness of Center in Achieving Goals

"Looking at the development of the training center in the past four years or since you have been associated with it, how well have the following goals been met?"

Goals	Mean	Standard Deviation
Provide financial assistance to those students who otherwise would not be in school	1.66	.68
Recruit and select bilingual/ bicultural social work students	1.67	.60
Act as advocate for the needs of Asians/Pacific Islanders	1.78	.61
Act as a support group to Asian/ Pacific Islander students	1.79	.64
Provide community-oriented training	1.85	.86
Organize social action in support of particular issues affecting Asians/Pacific Islanders	1.94	.72
Get the social work schools to recognize the needs of Asian/ Pacific Islander communities	1.94	.74
Provide opportunities for inter-ethnic communication among students and community people	1.97	.68
Provide training for Asians/ Pacific Islanders entering the social work field	2.03	.73
Identify and support legislation affecting Asian/ Pacific Islander communities	2.16	.90
Develop training materials and resources on the mental health of Asians/Pacific Islanders	2.59	.76
Get the social work schools to set up curriculum relevant to Asian/Pacific Islanders	2.74	.82

Note: Rating is from 1 (very well) to 4 (very poorly).

from the first year after it was founded had become increasingly disillusioned.

Respondents were classified according to their ethnic background to find out if those from the newer, emerging Pacific/Asian communities (for example, the Southeast Asians) gave a different evaluation than those from the more established communities (for example, the Chinese and Japanese). Ethnicity had no impact on a respondent's evaluation of goal achievement. The intensive interviews also indicated that positive and negative evaluations of the center cut across ethnic lines. The fact that the more established communities had more control of the center's organization and resources than did the emerging communities did not result in significant variations in their evaluations.

The length of supervisory experience and income were then used as indicators of relative professional status. Although professional status had no statistically significant impact on a respondent's evaluation of the center's goal achievement, the results were significant at the 0.10 and 0.13 levels for these two variables. Respondents with more supervisory experience and higher incomes tended to give higher evaluations on the Goal Achievement Index.

The Future of the Center

Corresponding to the evaluation of the center's performance in its previous four years was the assessment of its future. Respondents were asked whether the center should be refunded or a similar program in a different center should be established, and what new programs, if any, could be derived from the experience of the center.

While 87 percent felt that the establishment of the training center had been worthwhile, 40 percent said either that they would not favor the continuation of the center or were not sure if they would favor it. Some respondents assumed that because of policy changes in NIMH, calling for a drastic reduction of support for mental health training, the center would no longer receive funding for its present program.[3] Because of this, it was not possible to determine precisely how much the center's lackluster performance in its prior four years contributed to their lack of support for its continuation.

It should be noted also that little of the center's work could be used as a basis for innovative research, training, or community projects. The center left little information about the causes of its failure to achieve its potential. Thus, a careful evaluation of the history and development of the training center is very important because this experiment in community mental health training might carry significant implications for future programs in Pacific/Asian and other minority communities.

The Policies and Practice of Student Selection

Respondents expressed considerable disagreement with the policies and practice of student selection. Statistically, only 37 percent found the selection process acceptable. In the intensive interviews, respondents expressed concern about the overrepresentation of Koreans, Chinese, and Japanese. Many felt that more Associate in Arts students should have been awarded stipends. Others thought that the center should have concentrated on MSW training. Respondents also revealed concern over insufficient recruitment in the economically deprived segments of Pacific/Asian communities and among more recent immigrants. Specifically, there was widespread dissatisfaction with the recruitment of bilingual/bicultural students from each of the nationalities represented in the center. Those who were recruited as stipend students tended to fit the so-called "model minority" image of Pacific/Asians perpetuated by society. They tended to be from middle-class backgrounds and assimilated to the extent of being almost monolingual.

It should be noted that the recruitment of bilingual/bicultural students was singled out as a major issue in the Subpanel Report on the Mental Health of Asian/Pacific Americans of the President's Commission on Mental Health. According to that report:

> The stereotype of Asians and Pacific Americans as the "Model Minority" has led to the situation . . . that many Asian and Pacific subgroups have few bilingual/bicultural mental health personnel with the same background. (President's Commission on Mental Health 1978b:22)

The report also stated that:

> bilingual/bicultural factors certainly seem to be a very positive part of overcoming some of the traditional patterns of "underutilization" common in "mainstream" mental health services available to Asian and Pacific Americans. Bilingual/bicultural services tend to reduce barriers to accessibility of services, and stigma attached to seeking services. (President's Commission on Mental Health 1978b:18)

The responses to the question of how well the center had served the different levels of students reflected some of the problems involved in student selection. Table 12 shows that respondents believed that Associate in Arts students had been served least well by the center. Unfortunately, there was a much larger concentration of students at the AA level who were poorer, older, bilingual, bicultural, and more recent immigrants to this country.

One respondent indicated that the center should try to get the most product

per dollar invested. Since the costs of investment for an AA or MSW student were comparable, the center should concentrate on the MSW level. She felt that Asian communities would benefit more from trained MSWs than from AA paraprofessionals.

The overall problems in student selection are best summed up in this respondent's answer:

> The selection process favored American-born nonbilingual students at the higher degree levels, especially the MSW level. No conscientious effort was made to bring in a substantial number of immigrant community workers with bilingual skills who were mostly on the paraprofessional staff of agencies. The recruitment practices of the center definitely favored students who could have made it through the traditional educational channels anyway.

A Student Support Index was constructed by computing the mean rating of how well staff, council members, and field supervisors believed the center had supported the three levels of students. Since the level and length of these respondents' involvement with the center and with Pacific/Asian communities affected their evaluations, as noted above, one-way analysis of variance tests were done using this index as the dependent variable. The results were not statistically significant, perhaps because respondents had very different conceptions of what the student support functions should be. The tremendous variations in students' conceptions of this function have already been reported in Chapter 4, and the intensive interviews of staff, council members, and field

Table 12
Program Survey: Training Center's Service to Different Levels of Students

"How well has the training center served the needs of the different levels of students?"

Degree	Mean Rating	Standard Deviation
MSW	1.7	.66
BA/BSW	2.0	.64
AA	2.5	1.03

Note: Rating is from 1 (very well) to 4 (very poorly).

supervisors indicated that they shared the students'confusion. In addition, when problems arose due to the lack of clear-cut definition of this function, they were handled informally on a case-by-case basis rather than systematically.

Student Training

The respondents expressed a fairly high degree of satisfaction with the field training, with 66 percent answering that they were mostly satisfied. Among those respondents who had supervised one or more stipend students, 77 percent stated that their agency had developed a training program for the students. Most (70 percent) rated training center students about equal in ability and performance to other students at the same level.

However, respondents gave only a moderate rating when asked how well the training center had prepared the students for professional social work in Asian/Pacific Islander communities. There was widespread concern that the ethnic seminars, which constituted the main thrust of the center's special training, were largely duplications of ethnic studies courses: they did not provide professional training in community mental health—in terms of either clinical practice or administration. One respondent said:

> The training center had more impact in terms of sensitizing students to issues in community organizing, because most of the staff had been community organizers. The training center had not had much impact on the community in terms of providing clinicians and administrators to deal with mental illness or more severe mental health problems. Students should have had more exposure to mental health treatment methods and mental health administration.

The ethnic seminars were too general, lacked continuity, and were uneven in terms of representation. No knowledge base and curriculum materials evolved out of them. As one respondent stated:

> The center was funded on a five-year temporary basis with the goal of setting up a training program where the educational institutions can adopt it into their system. We've failed to do this and educational institutions are still very resistant.

In sum, while most of the respondents (91 percent) acknowledged that the center had provided training opportunities for social work students that were not available in colleges or communities, their general assessment was that the center had improved little during the previous four years. This overall assessment becomes even more depressing when one considers that the center had begun functioning without any curriculum materials, training methods, or personnel who were experienced in community mental health as teachers,

researchers, or practioners. As one respondent remarked:

> The training center did not actually provide any direct services (for example, training) to students as the name implied. The only function, for all practical purposes, was to provide stipends for Asian students.

One of the main problems in evaluating the training function of the center was that neither the training council nor the staff were in any sort of agreement as to what constituted good training. According to one respondent:

> There should have been a definite idea or agreement by the persons involved in this project as to what constituted good training and to this date there was no agreement, and in fact, many people who participated in the program, whether they were staff or council members, did not know what good training was, could not even enumerate those areas which could be considered good training . . . whether in fact the area was to be covered by agency or to be covered by school or whether there was any duplication within the training center—that was never determined.

An Assessment of the Center's Impact on the Schools of Social Work

In the past decade, the relationship between Pacific/Asian communities and social work programs in the coastal area has been marred by conflicts over such issues as the relevancy of curricula and the recruitment of students, faculty, and staff. These conflicts were manifestations of a general tension between minority communities and social welfare and academic institutions, including schools of social work.

Chapter 2 elaborated on the relationship between the training center and participating social work programs. University A had played a pioneering role in forging closer links with the various Pacific/Asian communities, and University A's social work training program, which was also funded by NIMH, received significant support from its own faculty members. Later, these faculty members also played important roles in the establishment of the Coastal Community Mental Health Training Center. Thus it is not surprising to find in Table 13 that respondents rated University A as the most supportive among the five participating schools. On the other hand, the relationship between the center and the school of social work at University B was damaged by a confrontation between the Asian student caucus and the school's faculty. As was pointed out in Chapter 2, the clash between Asian students and the social work faculty over the issues of recruitment and ethnic content was an important factor in the school's loss of training grants from NIMH in 1974-75. In addition, the center had, in practice, deemphasized support of the

Table 13
Program Survey: Supportiveness of Colleges to Training Center

"In your opinion, how supportive have the colleges been to the training center?"

	Extent of Supportiveness	
	Mean Rating	Standard Deviation
University A	1.7	.48
University B	2.0	.67
Community College A	2.2	.78
Community College B	2.3	.68
Community College C	2.6	.81

Note: Rating is from 1 (very supportive) to 4 (highly unsupportive).

Table 14
Program Survey: Impact of Training Center on Schools of Social Work

"What impact has the training center had on the schools of social work?"

	Extent of Impact	
Areas of Impact	Respondents' Mean Ranking	Standard Deviation
Student recruitment	1.9	.76
Linkages between community and schools	2.2	.96
School policies and meeting Asians/Pacific Islanders	2.7	.80
Faculty/administrator recruitment and promotion	2.7	.80
Curriculum	2.8	.79

Note: Rating is from 1 (a lot) to 4 (none).

community college paraprofessional social work programs. Their relatively lower levels of support for the center are, therefore, not surprising.

A series of one-way analyses of variance with selected independent variables using this index indicated that the longer and more active a respondent's association with the center, the less support the respondent felt the schools had given to the center. The results, however, were not statistically significant.

Table 14 answers the critical question of what impact the training center had on the participating schools of social work. Student recruitment received the highest impact rating, followed by the establishment of linkages between communities and schools. However, the respondents felt that the center had little impact on school policies, recruitment and promotion of faculty administrators, and curricula. The respondents also indicated that institutional bridges between the schools and the center, such as school-community advisory boards, were not built. Such linkages, where they did exist, were personal in nature, consisting of the involvement of individual faculty members in community issues, for example. In sum, then, the responses to the question of the center's impact on the schools were generally negative.

In the series of analyses of variance with selected independent variables conducted on this index, as in the case of the previous index, the more the respondents were involved in the center, the more negative they were about the center's impact ($p = .05$). The respondents who had longer associations with the center, more on-the-job contacts with Asians, and work experience in Pacific/Asian agencies also had lower mean ratings on this school impact index, but the results were not significant.

Why was the center's impact on the colleges so minimal? One possibility is that academic institutions are resistent to social change. It is true that in the 1960s and 1970s, the rigidity of academic institutions had resulted in numerous clashes with minority communities.[4] On the other hand, part of the problem was obviously that the center was not able to build academic or professional legitimacy. As one respondent remarked:

> The center did not have a good understanding of social work education. It was not knowledgeable about the course contents of the various schools. It lacked a coherent, organized philosophy about what, when, and how to do training.

Another respondent said:

> We began with a lot of enthusiasm. The advocacy and lobbying efforts had paid off. We got the grant to built the center. Then we realized that we weren't prepared to do community mental health training. We said to NIMH, "These are all the things that are wrong with the way academe traditionally trains mental health workers." We wanted to do it

differently. But in terms of content, we were still at square one at the end of four years. We had accumulated little knowledge about training. If someone asks us, "What have you learned in the past few years?" we could probably say something about how not to run a training program but we couldn't say much about how we should run it.

One methodological problem should be noted. No specific impact objectives were explicitly decided upon by the center in terms of the number of faculty to be hired, changes to be made in the curricula, or courses to be adopted. Nor was an impact timetable ever established. It is therefore not possible to measure the impact of the training center on the schools or in other areas in a systematic manner.

In the intensive interviews, some respondents said they thought the schools used the training center as a broker to get stipends for their students but did not provide any direct contribution to curriculum development at the center by, for example, making faculty available for consultation. On the other hand, the training center had no systematic strategy for influencing the universities' curricula. The overall relationship between the center and the universities, therefore, remained superficial; no substantial collaboration between them took place in the five-year existence of the training center.

Some distinction should be made, however, between University A and University B. University A had a closer relationship with Pacific/Asian communities historically. Although no substantial collaboration between University A and the training center took place in research and curriculum development, the school did independently hire a Chinese female tenure-track faculty member and another Asian faculty member was conducting significant research on mental health service delivery in Pacific/Asian communities.

As far as the community colleges were concerned, even less effort was exerted by the training center to establish closer linkages, with the consequence that no curriculum materials for paraprofessionals were developed.

The Relationship Between the Training Center and Pacific/Asian Communities

Although the center published a newsletter, certain aspects of its work were not adequately publicized. As a result, many respondents were not knowledgeable enough to give opinions about some of its vital functions. For example, a large percentage of people responded "don't know" when asked whether the center "had solicited and received sufficient input from each Asian/Pacific Islander community." The percentage ranged from 88 percent for the Cambodian community to 48 percent for the Chinese and Japanese

communities. The center itself had no systematic documentation on what kind and how much input it had solicited from each community, which made evaluation of this area of its performance doubly difficult.

Data on how well the center had served the needs of the various Asian/Pacific Islander communities are presented in Table 15. Ratings were divided into two groups, those from members of the established communities (Chinese, Japanese, Pilipino, and Korean), and those from emerging groups (Cambodians, Samoans, Thais, and Vietnamese). The mean rankings for the former were all below 2.0 on a scale of 4, with 1 indicating that community needs were very well served. The mean rankings for the latter were all above 2.0.

Data on the representation of each community in the center as students, staff, council members, and fieldwork supervisors showed a similar pattern. In Table 16, the mean ratings indicate that the Chinese, Japanese and Koreans were most adequately represented, with the Pilipinos and Samoans falling in between, and the most recent immigrant groups (Cambodians, Vietnamese, and Thais) being least adequately represented.

An index of the respondents' evaluation of how well the center had served

Table 15
Program Survey: Training Center's Service to Asian/Pacific American Communities

"How well has the training center served the needs of each Asian/Pacific Islander community?"

	Respondents' Mean Rating	Standard Deviation
Chinese	1.7	.62
Korean	1.8	.67
Pilipino	1.9	.61
Japanese	1.9	.60
Samoan	2.2	.87
Vietnamese	2.5	.72
Thai	2.6	.94
Cambodian	2.7	.92

Note: Rating is from 1 (very well) to 4 (very poorly).

Table 16
Program Survey: Adequacy of Representation of Each Asian/Pacific American Community in Training Center

"Do you feel that each Asian/Pacific Islander community has been fairly repesented in the training center?"

Community	Percent of Respondents Rating Community Representation as Adequate in the Training Center Positions of:				
	Stipend Student	Staff	Council Member	Field Work Supervisor	Mean*
Thai	28	18	6	13	16
Cambodian	38	22	22	24	27
Vietnamese	63	17	12	30	31
Samoan	76	60	26	38	50
Pilipino	87	62	38	50	59
Korean	91	90	63	75	80
Chinese	92	75	100	85	88
Japanese	83	100	91	79	88

*Sum of percentages divided by 4.

all community needs was constructed by computing the mean ratings on their responses to the communities needs question. An analysis of variance test showed that lower ratings were given by the respondents who had more on-the-job contacts with Asian/Pacific communities ($p < .00001$). Lower ratings were also given by respondents who had a longer period of association with the center and those who worked in Pacific/Asian agencies, but the results were not statistically significant.

A series of analyses of variance were also conducted with the mean rating index of the respondents' answers to how well each Pacific/Asian group was represented in the center. One statistically significant finding emerged from these analyses. Respondents who worked in Asian agencies gave the center lower ratings on the community representation index than respondents who worked in non-Asian agencies ($p = .03$).

In order to find out if the respondents from emerging communities were more likely to feel that their community needs were slighted, an analysis of variance was done with the mean rating of representation of each group as the dependent variable and the ethnicity of the respondent as the independent variable. The evaluation on how fairly each community was served was *not* affected by the ethnic background of the respondents.

It should be noted that many council and staff members were recognized local and national Asian/Pacific leaders. They had established ties with the community before the center was formed. By and large, they were representatives of the new professional stratum rather than members of the old guard community establishment or grass-roots leaders. The conclusion that can be drawn from this is that, while many individuals associated with the center served the community as professionals, the center per se did not establish a reputation and an identity vis-a-vis Pacific/Asian communities.

A second conclusion is that the center did not have extensive connections with the old guard establishment or the grass-roots movements. There was a tendency by those involved with the center to define community ties in terms of relationships with professional social service agencies. In fact, this limited view was reflected in the composition of the training council and its community resource groups. As one respondent remarked in an intensive interview:

> The original proposal specifically called for the involvement of community people, such as using some elderly Asians, low-income people, etc., as resource persons and consultants. . . . But all we had down there were middle-class Asian social work types and professionals. . . . We were always talking about poor people, you know, not being represented in the agencies and not sensitive to their needs, and that was one way to avoid that, but it was never done. . . . We worked with the indigenous poor and applied for grants supposedly to help them. But

once we got our grants, the indigenous poor were forgotten very quickly.

In discussing community ties, the ethnic community resource groups should also be mentioned. In September 1976, in an effort to broaden community input into the center, the staff proposed establishing resource groups from each Pacific/Asian community. No specific question was asked in the program survey about these resource groups; however, their significance was assessed through the intensive interviews.

The resource groups were to assist in field placement, interpretation of community needs, outreach in the communities, recruitment of students, and program development. They were advisory bodies, and some of them provided valuable assistance to the center. Their members had professional backgrounds very similar to those of the center's council members. In fact, the original proposal for the formation of the groups stated that they would serve as a pool for future council membership. In many respects, their functions were similar to the council's, with the exception that they were advisory and not policy-making bodies. However, the resource groups could not be a substitute for capable staff and council leadership. In effect, they duplicated the functions of the council without having a vote on policy decisions. Eventually, the resource groups died out.

An Evaluation of the Staff's Performance

The respondents were moderately satisfied with the performance of the staff in implementing the goals of the center, with a mean of 2.1 on a scale of 1 to 4 (most to least satisfied). They also felt that the staff had improved somewhat over the four years in their ability to implement the center's goals, but they did not think there had been any significant or remarkable improvement in overall staff performance.

When staff activities were broken down into twelve categories, their ratings fell into three identifiable ranges (see Table 17). There was considerable concern over student placement and field supervision. This concern was also expressed in the student survey, and two sources of problems in these areas were cited:

1. The lack of clearly defined roles for the school field coordinators, center field coordinators, and field supervisors (in some cases, the center field coordinator was also the supervisor).

2. The lack of facilities and expertise for professional training in the community agencies.

As far as staff supervision was concerned, the center experienced some major problems. The first was that it did not recruit capable staff leadership.

In spite of the fact that earlier evaluations of the center had already revealed a crisis in staff leadership and a failure to take staff development seriously, no effort was made to conduct a national search for a director with the training and experience to build the center on a sound foundation, to provide direction, and to develop all aspects of the center including professional training and research and linkages with communities, schools, and staff. Rather than widening staff recruitment, the center tended to hire personnel based on informal ties with the small Asian American social work circles in the coastal area. This contributed significantly to the inability of the center to establish training programs and a knowledge base for community mental health in Pacific/Asian communities.

In the five-year history of the training center, little attention was given to staff training and development. As one respondent remarked:

Table 17
Program Survey: Staff Performance

"In your opinion, how well has the staff carried out the following activities?"

	Rank	Respondents' Mean Rating
Office management	1	1.5 and below
Budgeting/financial planning	2	
Communication with students	3	1.6 to 1.9
Communication with schools	4	
Report writing	5	
Proposal development, research and planning	6	
Staff development and training	7	
Communication with other agencies	8	2.0 and above
Communication with council	9	
Communication with communities	10	
Student field placements and supervision	11	
Staff supervision	12	

Note: Rating is from 1 (very well) to 4 (very poorly).

> Even though most of the staff came into the program with limited administrative, teaching, research, and curriculum development experience, a systematic plan could have been made from the start to give them training in those areas, for example, in-service training, use of really competent consultants, and temporary leave to attend professional workshops or to take courses at the universities.

The staff's communication with the council, communities, and other agencies was also given a relatively poor rating. The relationship between the staff and communities, for example, varied considerably. In the case of the more established communities, some formal working relationships and channels of communication were established from the beginning. However, any connections with emerging communities tended to be based on the personal contacts of the few staff members who had ties in those communities. Formal linkages were never established.

The association between the staff and the council was strained. From the center's inception to its second year, it was basically characterized by paternalism on the part of the council. In the second year, after the first council chairperson had resigned, efforts were made to build a more structured relationship. Unfortunately, several factors contributed to the failure of the council and the staff to develop a smoothly functioning division of labor: an influx of new council members who were not oriented to the center's goals and objectives, the self-interests of subgroups, the lack of overall staff leadership, and uneven leadership in the council committees. By the fourth year, mutual mistrust and lack of confidence in each other's professional capabilities led to severe strains between the staff and the council. There was a tendency for the council to extend its jurisdiction beyond policy and program questions to problems of day-to-day operations. In turn, the staff director's inexperience in administration, training, and policy formation perpetuated the lack of direction that had existed from the beginning.

An Evaluation of the Training Council's Performance

The training council's performance was evaluated by responses to the question, "How satisfied were you with the performance of the council?" The overall mean of the responses was about 3 on a scale of 6. Table 18 shows that for each of the five major activities of the council, the mean ratings and standard deviations were very similar. The main reasons for the council's performance problems have already been indicated in the above discussion of the relationship between the staff and the council. Its lack of experience in dealing with the policy and program issues connected with a training center for both undergraduate and graduate social work students seems to have been

the single most significant factor.

In singling out this factor, however, it must be noted that several council members did have extensive experience in social work education. Their expertise should have been utilized more thoroughly. In the final analysis, the success or failure of the training center depended on a creative and persistent cooperation among staff, council, schools, and communities that, by and large, did not materialize in the development of the center. The working relationships among those institutions did not show any significant improvement over time.

A series of analyses of variance with selected independent variables on an evaluation index of council performance showed some interesting results. First of all, respondents who had longer periods of association with the center and those who were more active gave the council lower ratings ($p = .05$ and .04 respectively). Similarly, respondents who had more on-the-job contacts with Asians or who were employed by Pacific/Asian agencies gave lower performance ratings ($p = .04$ and .05, respectively). Finally, the respondents with lower professional status as reflected in lower incomes tended also to be more negative.

Over a four-year period, the council evolved from an informal structure based on friendship ties and paternalistic leadership to a more formalized structure with bylaws, subcommittees, objectives, and plans. The first council chairman had played a positive and indispensable role from the time of negotiations for funding to the second year after the establishment of the center. However, by the second year it had become apparent that a formal struc-

Table 18
Program Survey: Council Performance

"How satisfied were you with the performance of the Council in the following activities?"

	Mean Rating	Standard Deviation
Financial matters	2.7	1.09
Student matters	2.7	1.03
Policies and procedures	2.8	1.10
Personnel matters	3.1	1.04
Program development	3.3	1.23

Note: Rating is from 1 (very satisfied) to 6 (very dissatisfied).

ture, administrative procedures, delineation of the respective functions of the council and staff, and both short-term and long-term planning were needed.

Unfortunately, the council had, by and large, failed to develop a sound multiyear plan or clear objectives and standards of evaluation with which to measure the performance of the training center. The council was additionally hampered by uneven leadership in its various subcommittees and the decision of several key council members to become less involved or to sever their associations with the center.

The council, together with the staff, did make many attempts at short-term and long-term planning, but a look at the records and files of the center reveals that many of these plans were aborted and no thorough evaluation or criticism of them was subsequently made. These included plans to develop curriculum materials, to build a linkage between the center and Pacific/Asian communities, and to influence the schools of social work in their recruitment of faculty and administrators.

The council's most outstanding handicap was that it lacked a conception of what the training center should become and what model should be used to compare as well as to evaluate its work. While the center could have utilized numerous evaluation studies of community mental health programs[5] as a basis for its own training methods and evaluation models, it never took advantage of these sources. It therefore faced the task of conceptualizing and implementing its own model of community mental health training to serve the needs of Pacific/Asian communities in a unique way. Although the council was not successful in developing such a model, this evaluation and summation of the experience of the center should provide useful information for future training programs.

The Relationship Between Different Areas of Performance Evaluation: A Factor Analysis

The preceding evaluation by staff, council members, and field supervisors covered the training center's performance in eight areas: its achievement of program goals, its satisfaction of community needs, the level of community input it generated, its impact on social work programs in participating schools, the level of support it generated in these schools, its development of support for students, staff performance, and council performance. Evaluation indexes were constructed in each of these eight areas. These have already been separately analyzed in previous sections of this chapter. By way of summary, it should be noted that the evaluations for the eight performance areas were, in most instances, highly correlated, as shown in Table 19. Thus, for example, the goal achievement index was significantly correlated with all

Table 19
Zero-Order Correlations between Training Center Performance Evaluation Indexes

	Community Needs Satisfaction	Community Input	School Impact	School Support	Student Support	Staff Performance	Council Performance
Goal achievement	.56***	.47*	.62***	.63***	.63***	.55***	.68***
Community needs satisfaction		.21	.53**	.73***	.77***	.28	.63***
Community input			.41*	.14	.23	.33+	.22
School impact				.62***	.65***	.55***	.69***
School support					.78***	.41*	.71***
Student support						.54***	.70***
Staff performance							.60***

$+p < .05$
$*p < .01$
$**p < .001$
$***p < .0001$

other indexes. In the correlation matrix of performance evaluation indexes, there were only five coefficients which were not statistically significant and even these still show a moderate level of correlation, from .14 to .28.

A factor analysis was conducted to determine how many important common dimensions or components of performance evaluation there were. Using the principle factor method with iterations, two common factors were found. The results in Table 20 show that factor 1 accounted for 87.9 percent of the common variance and 56.8 percent of the total variance of the eight evaluation indexes.[6]

This leads to the conclusion that respondents were very consistent in their evaluations of the eight performance areas: if they rated the center's performance highly in one area they tended to rate it highly in other areas also.

Summary

The evaluation of the center by the staff, council members, and fieldwork supervisors by means of a questionnaire survey and intensive interviews indicated that the center experienced major problems in a number of goal areas. Furthermore, the distinction between goals and objectives was never explic-

Table 20
Factor Matrix from a Factor Analysis of the Eight Performance Evaluation Indexes (Using the Principal Factor Method with Iterations)

Evaluation Index	Factor 1	Factor 2
Goal achievement	0.80	0.23
Community needs satisfaction	0.76	–0.32
Community input	0.37	0.44
School impact	0.79	0.19
School support	0.84	–0.32
Student support	0.87	–0.20
Staff performance	0.62	0.31
Council performance	0.84	–0.01
Eigenvalue	4.54	0.62
Percent of common variance	87.9%	12.1%
Percent of total variance	56.8%	7.8%

itly made, which resulted in some contradictions in respondents' conceptions of what the center *should* have achieved.

In terms of student selection, the most important interrelated issues were the failure to recruit more bilingual/bicultural students from each of the communities and the de facto overselection of MSW monolingual students. In addition, the training provided by the center consisted mostly of an orientation to Pacific/Asian community issues and history. There was very little professional training on bilingual/bicultural aspects of community mental health.

In the minority social movements of the 1960s and 1970s, universities were often portrayed as perpetuating racial oppression through student, staff, and faculty recruitment policies and support of theories and ideologies that defended white domination of minorities. Although the expansion of the multiversities in the 1960s (Kerr 1972) resulted in an increased recruitment of minorities into academic institutions, it also created more unwelcome academic research and training in minority communities. The training center was established as an alternative to traditional academic training programs. However, it never developed a collaborative relationship with its participating academic institutions, and, on the whole, the relationship that did exist did not change significantly over the years. The training center developed ties primarily with a certain segment of the community, namely the social service professionals. It had no ties to speak of with the grass-roots organizations or the new immigrant populations.

In the beginning, the people who were involved in the center as council members, staff, students, and volunteers were enthusiastic and idealistic about its potential. Individuals who were active in other areas of the Pacific/Asian American movement were drawn there. In time, however, the initial drive to use the center as a vehicle for social change in Pacific/Asian communities and in community mental health systems decreased. Yet, the center had not developed the administrative, research, and managerial expertise to function as a strictly professional agency in the traditional sense. As one respondent remarked:

> At the beginning, people had a lot of energy and commitment to the communities. By about the third year, everything had become just a job. I expected the training center to be more involved in political and social issues. Now our morale is no different from any other agency, but we haven't acquired the skills to view the center like a traditional agency.

The analyses of variance on the evaluations of the center's performance showed that respondents who had longer associations with the center, had more on-the-job contacts with Asians, or had worked in Pacific/Asian agencies tended to give the center lower performance evaluations. The disillu-

sionment of the original participants and those who were active in Pacific/Asian communities was revealed by these statistical findings. Respondents who had lower professional statuses (as indicated by income and years of supervisory experience) also tended to give lower evaluations. This indicated that rank-and-file social service workers were more critical of the center than respondents with higher professional statuses. On the other hand, positive and negative evaluations of different areas of the center's performance seemed to cut across ethnic lines. Respondents from newer immigrant groups were not, for example, less favorable to the center than those from established communities. Apparently there were no coalitions or crystallizations of opinions about the center based strictly on respondents' ethnic community affiliations.

Notes

1. For a discussion of employment, unemployment, and salary levels for professional social workers nationally, see Hardcastle and Katz 1979.

2. For a discussion on the distinction between goals and objectives, see Porter 1977.

3. For a discussion of historical developments in NIMH policies and practices, see Denham 1982.

4. For discussions on problems in the relationships between academic institutions and minority communities and how they might be resolved, see the special 1977 issue of the *Journal of Social Issues* edited by Montero and Levine, especially the articles by Bengston et al., Maykovich, Weiss, and Moore.

5. For examples of evaluations of community mental health programs, see Binner 1973; NIMH 1974b; Feldman and Windle 1973; Kaplan and Roman 1973; and Musto 1975.

6. The proportion of total variance explained by factor 1:

$$= \frac{\sum_{j=1}^{n} a_{j1}^2}{n} = \frac{4.54408}{8} = 56.8\%$$

The proportion of common variance explained by factor 1:

$$= \frac{\sum_{j}^{n} a_{j1}^2}{\sum_{j}^{n} h_j^2} = \frac{4.54408}{4.54408 + 0.62493} = 87.9\%$$

For factor 2, the total variance explained = 7.8 percent; common variance = 12.1 percent.

6

Implications of the Training Experience

In this book, some of the issues in and obstacles to minority community-based mental health training have been identified, as reflected in the history of the Coastal Community Mental Health Training Center. This chapter discusses the implications of these findings.

Pacific/Asian American Community Mental Health Training in the Context of National Policies

Over twenty years ago, the Joint Commission on Mental Health and Mental Illness was established by the United States Congress to investigate and report on the problems of mental health in the U.S. After several years of study, it published *Action for Mental Health* in 1961, which led to the creation of community mental health services. In 1977, President Carter established the President's Commission on Mental Health. After a year of investigation, it also published a report.

Pacific/Asian Americans criticized the Carter commission for failing to appoint Asians and for not giving sufficient attention to minority needs. As Kuramoto (1978) observed, the final report contained no specific sections dealing with minority issues and the problems of racism; instead, references to the needs of racial minorities (and, occasionally, specific references to Asian and Pacific Americans) were sprinkled lightly throughout its recommendations. However, the final report did point out the need for training minority mental health personnel and for some increase in research and training support.

In addition, a subpanel to the President's commission (1978b) presented a report on the mental health of Asian and Pacific Americans that included these specific recommendations regarding their training in the mental health field:

1. To establish regional Asian and Pacific American multidisciplinary mental health training centers.
2. To develop culturally relevant curricula and modalities of mental health care.
3. To recruit and train bilingual/bicultural personnel and to reexamine licensure requirements faced by bilingual/bicultural professionals.

4. To support research on Asian American mental health needs and issues.

These recommendations of the subpanel paralleled a proposal made at the National Asian American Psychology Conference (Long Beach, California, 1976) to establish one or more training centers that would, as their primary task, "coordinate field placement for practical experiences, provide bilingual and bicultural training, enhance research skills, and offer interdisciplinary approaches in areas such as law, social work, psychiatry, and folk healing methods as well as clinical, community, and social psychology" (Sue and Chin n.d.).

The subpanel on the mental health of Asian/Pacific Americans challenged the Carter commission on some of its basic premises regarding community mental health as well as on a number of specific points. For example, in the report it submitted to the commission (1978b), the subpanel stated that:

> the Task Panel on Special Populations and the President's Commission on Mental Health must simultaneously confront the basic, causal, societal factors which produce the conditions which adversely affect special populations. Unless this is done, causal factors will be dismissed in favor of blaming the "victim."

However, from the experience of the training center it appears that a number of important issues in minority community mental health training and research were not anticipated by the subpanel. In this chapter, these issues will be elaborated on.

The Feasibility of Community-based Training Programs

In a comparison of a school-based, school-controlled training program and a community-based, community-controlled training center, Murase (1977b) pointed out the strengths and weaknesses of each. A school-based program that has a strong community board may be in a better position to promote ethnic content in the curriculum; recruitment of minority students, faculty, and administrators; and utilization of the school's specialized and technical expertise. Since universities are generally resistant to community participation and shared control, a community-based training center, because it lacks direct organizational ties with participating schools, obviously has less influence. In order to establish a training program that is both adequate in itself and capable of influencing participating schools, a community-based agency must have sufficient funding and a level of operation adequate to recruit a diversified staff.

On the other hand, there is no doubt that a community-based center provides students with much more exposure to ethnic issues and can perhaps help them in gaining a sense of ethnic identity and consciousness. Important as

this is in the professional training of minority social workers, it must go hand-in-hand with providing specialized skills in direct and indirect practice.

The performance of the Coastal Community Mental Health Training Center was circumscribed by a number of factors leading to a relative lack of success in achieving its overambitious but vaguely defined goals and objectives. In the meantime, two decades after the advent of the community mental health movement, some comprehensive service programs encompassing many of the fields of social work practice have been established in Pacific/Asian communities. In his national study of community mental health services in Pacific/Asian communities, Murase (1981:10) identified one such center—the South Cove Community Health Center of Boston. It not only provides health and mental health services, but also, at the same location, an elementary school, a gymnasium, an auditorium, a "little city hall" staffed by representatives of major city departments, a day care center, and a 160-unit high-rise apartment complex for the elderly. It is possible that interdisciplinary training centers in social work could be established in close collaboration with systems such as this.

If, given its funding, personnel, and structural limitations, the training center was unrealistic in its goals and objectives, its intention not to confine itself to traditionally accepted training methods should not be lightly dismissed. Lacking the capacity and resources to achieve its objectives independently, it attempted to do so through coordinating the efforts of schools and communities. Because of the traditional antipathy between these two groups, the center found itself time and again closely aligned with the communities and in an adversary relationship with the schools.

Although this attempt at coordination was not very successful, an alternative approach should be considered before abandoning community-based and community-controlled training programs in favor of school-based and school-controlled ones. From the failures of the training center and from a systematic survey of current successes in the field, it appears that training is best conducted as part of an integrated community training, research, and service program. The key is that training and research should be carried out in conjuction with service delivery in the communities.

This would solve several of the problems faced by the Coastal Community Mental Health Training Center. For example, little or no research was done at the center itself. At the same time, the center's participating schools of social work, in spite of the efforts of a few faculty members, adopted policies of benign neglect in terms of Pacific/Asian American research and curriculum development. There was, consequently, no reliable knowledge base to guide the center's training. Moreover, stipend students were placed in community agencies with widely divergent training capacities. The training center, at

best, performed a coordinating role; it had little control over the quality of the field experience. As a result, there were great differences in the quality and variety of its students' field training. In an integrated system, research and training would be conducted within the context of concrete community needs and be continuously tested in the field.

Organizationally, an integrated system would also have the advantage of a formal structure of authority, responsibility, and accountability among its research, training, and service components. Since the relationship among these components in the Coastal Community Mental Health Training Center—the schools, the field agencies, and the center itself—was neither formal nor clearly defined, it had to be continuously renegotiated.

Finally, the concept of an integrated system of training, research, and service is consistent with the recommendation of the Asian American Task Force on Social Work Education to build consortium-satellite systems centralizing indirect services (training, research, planning, and administration) and decentralizing direct services in satellite community agencies (Murase 1973). For field work training, a student could therefore be placed either in a satellite agency or a central administrative research planning office or both. The consortium-satellite model is not, however, a panacea. It bears a resemblance to the "umbrella agency" concept, and must of necessity optimize its mix of services in terms of variety, quantity, and quality according to economic, political, and social constraints. This optimization is more than a linear programming problem, for it entails bargaining and compromises among the communities and between the communities and the institutions that provide funding.

The Problems of Adapation: From Community Storefront to Professional Training and Research

During the civil rights movement of the 1950s, there was a facade of calmness in Pacific/Asian American communities which was irrevocably shattered by the social and political upheavals of the late 1960s and early 1970s. The weight of a century of racism, the mass influx of new immigrants, the rise in racial and class consciousness due to the influence of the working class movement, the antiwar movement, and the minority political movements combined to produce a climate of change in Pacific/Asian communities. The resulting Asian American movement was an open response to this multitude of social, economic, and political pressures by communities that had been silent for decades (Wong 1972).

Initially, community "storefront" organizations were formed to respond to

various issues. They were staffed primarily by nonprofessional activist volunteers. In the span of a decade, however, most of these storefront organizations disappeared, some having been transformed into professional, diversified service agencies. To be successful, social movements require organization and leadership (Wood and Jackson 1982:3-11), and the early phases of the Asian American movement had attracted charismatic leaders and individuals with community organizing skills. They were skilled in mobilizing the people for political action, but they had not been trained in office management, program planning, research, and other skills required in running a bureaucratic organization such as a multiservice agency.

Furthermore, many individuals who were drawn into community mental health from earlier participation in the Asian American movement had never received clinical training in mental health. Examining the backgrounds of the Coastal Community Mental Health Training Center's staff, for example, revealed a preponderance of individuals who had community organizing backgrounds but were relatively weak in other types of indirect service training and experience and in direct service skills. Because of this, the center was ill-equipped to conduct training, planning, and research and to make an impact on the profession of social work and community mental health.

Unquestionably, many staff members had played significant roles in organizing and lobbying for the funding of the center and could still be effective in grass-roots organizing. However, the need to recruit members with other professional expertise and the need for staff development were never considered seriously.

In the recruitment of the first staff director, for example, the candidate field was narrowed to two people after a superficial search, and one of them dropped out of contention. Later, despite serious criticism and low evaluations of his performance, the lone candidate was retained for almost four years as director.

In sum, the training center did not adapt well to the evolving needs of Pacific/Asian communities and to changes in national policies vis-a-vis social work and mental health training. It did not change with the times nor did it work toward transforming its existing structure and composition to meet the new realities in communities and in the field of mental health. This is not to suggest that all training should focus primarily on narrow professional specializations, such as therapeutic skills. The tension between the need for indirect and direct practitioners, between the need for generalists and specialists, will always exist. A training program must be able to serve the present needs of communities and still be prepared for future shifts in social service and manpower requirements so as not to become functionally obsolete.

Commonality and Diversity: The Relationship between Overall Pacific/Asian American Interests and Individual Group Interests

The concept of a single Asian American interest or group that emerged in the late 1960s was a product of the history of racism in the United States. The diversity of Asian groups had always been negated by the dominant society through stereotyping, social labeling, and restrictions on cultural as well as political expression. As a result, Asians or Orientals were treated as one homogeneous group.

The one thing these groups did have in common was the way in which they had been subjected to racial oppression. Because of this and because of the relatively small size of their individual ethnic populations, they found it politically and economically advantageous to develop coalitions and alliances at the local, regional, and national levels in the late 1960s. A decade later, Asian concerns were recognized to some extent even in the legislative and executive branches of the federal government. What began as a movement based on grass-roots coalitions, primarily among Chinese, Japanese, Pilipinos, and Koreans, had become formalized through the establishment of special offices devoted to Asian American concerns in various departments and branches of the government. In the process, other Asian groups (such as Vietnamese, Cambodians, and Thais) and Pacific Islanders (such as Guamanians, Hawaiians, and Samoans) came to be incorporated under the Asian American rubric.

The common experience of Pacific/Asian Americans with racial oppression and their need to accumulate strength through numbers is self-evident. However, since Asian and Pacific Islander groups vary considerably in size as well as in political and economic strength, the interests of each group must be protected. It is too easy for the needs of the more established groups to overshadow those of the coalition's more recent additions.

In the case of the training center, for example, a decision was made early on to promote Pacific/Asian American interests in general, not to offer specific components for each ethnic population. Yet, in fact, some staff members became involved almost exclusively with a particular group. Furthermore, some respondents in the surveys observed that the groups with greater representation in the training center, the Chinese and Japanese, for example, took a paternalistic stand toward other groups. Finally, the level of community mental health and social service capacity varied tremendously from one community to another depending on how recently the group had immigrated, its cultural acceptance of the American social service system,

and the availability of professional manpower. In practice, then, the issue of how to take into account the diverse needs of each group became more important than the issue of how to promote the commonality of interests among the groups.

This is not to deny that there are important common interests among these groups, including the problems and psychological stresses of being bilingual-bicultural, of immigration, and of unemployment, as well as basic issues in grass-roots organizing and participation in the development of community mental health and service delivery systems.

The problem was rightfully recognized in the report of the Asian American Task Force of the Council on Social Work Education (Murase 1973) and in the report of the Special Populations Subpanel on the Mental Health of Asian/Pacific Americans (President's Commission on Mental Health, 1978b). Both noted that emerging communities were being slighted in terms of the actual allocation of funds and manpower. Under these circumstances, it was necessary for these groups to make special efforts to promote their own interests or run the risk of suffering benign neglect within the Pacific/Asian coalitions.

This conflict between the common interests of all Pacific/Asian American groups and the unique interests of individual groups was manifested in a number of ways throughout the history of the training center. For example, staff members who were responsible for field coordination in a number of communities decided in one instance to concentrate only on their own communities. In the case of student recruitment, a decentralized model was used to avoid this problem in recruitment policies and practices. As far as seminars were concerned, some survey respondents objected to an insufficient coverage of emerging communities, while others complained that the commonality of Pacific/Asian American problems was not properly addressed.

Interestingly, the survey data did show that all groups shared the feeling that some groups had been slighted in the distribution of the center's power and resources. Since members of the emerging communities were no more likely than those of the established communities to be dissatisfied about this, it was not a question of vested interest on the part of those who had most suffered from the problem. It is conceivable that some emerging groups were more concerned about gaining entry into the center than about the adequacy of their representation and share in decision making.

The resolution of this conflict between the common concerns and the diverse needs of Pacific/Asian Americans has become even more urgent with the dramatic growth of some groups, such as the Southeast Asians, and the increasing visibility of others in national as well as local politics.

The Resistance of Academe to Minority Community-Based Training

After more than a decade of experimentation, participation, and shared control, schools of social work and Pacific/Asian communities still have not established a modus operandi for genuine cooperation. Academic and institutional inertia and, for better or worse, faculty resistance to any impingement on academic autonomy have been powerful barriers to community participation and shared control (Veblen 1954; Riesman 1958). Clark Kerr, a former president of the University of California and chairman of the influential Carnegie Commission on Higher Education, observed in a 1972 Postscript to his 1963 Godkin Lectures (1972:131):

> The university has been shocked by many external and internal crises over the past few years, but it is remarkable not how much has changed but how little has changed on so many campuses in those areas that are under faculty control and where the faculty feels strongly about its control. The more the environment has changed, the more the organized faculty has remained the same. It has been the greatest single point of institutional conservatism in recent times, as it has been historically. Little that it has held dear and that it could control has been allowed to change.

This resistance to change is often defended in the name of academic freedom.

Kerr's Postcript also questioned whether the turmoil experienced by universities in the late 1960s and early 1970s (student strikes, the antiwar movement, etc.) necessitated basic changes to his 1963 conception of the American university. Essentially, he answered this question by defending and elaborating on his earlier view that the American university is different from either the English model of classical learning or the German research university of the nineteenth century in the attention it gives to public service and involvement with the larger society.

Articulating the English view, Cardinal Newman of Oxford University, who was also the founder of the University of Dublin, described (1947) a university as:

> the high protecting power of all knowledge and science, of fact and principle, of inquiry and discovery, of experiment and speculation; it maps out the territory of the intellect, and sees that . . . there is neither encroachment nor surrender on any side.

In the German model of the nineteenth century, the university was equally insulated from the larger society. At the heart of the university was its graduate school of arts and sciences, the solidly professional schools, and certain research institutes (Kerr 1972:6).

In describing the less insulated American model, however, Kerr did not point out that, in large measure, university service and involvement have been dictated by the funding priorities of large corporations and the federal government (Bowles and Gintis 1976). This makes the idea of academic freedom Janus-faced and hypocritical in practice. On the one hand, it has been allowed to be somewhat compromised in order to secure private and federal support. On the other, academe has been remarkably resistent to demands for change from minority communities.

In the case of the Coastal Community Mental Health Training Center, for example, universities were unwilling to develop any serious collaboration with the center because they did not have total control over the training program. Yet when academe did control such programs, it traditionally claimed sole jurisdiction over both training and research.

A lack of reciprocity has long characterized the relationship between scholars from academic institutions and the minority communities they study. In the 1960s and 1970s, minority groups became increasingly sensitive to what they considered the exploitation of their communities by researchers. Interviews in 1974 of directors of survey research studies on minority and poor communities revealed that in most cases community members did not help shape the design and interpretation of research and little effort was made to upgrade the job skills and employability of indigenous interviewers or to provide referrals and other services to survey respondents (Weiss 1974:20). In the war on poverty, a lot of money went into pure research—studies of conditions, evaluations of programs, and analyses of problems (Weiss 1974:21).

Minority communities protested against the one-sided control exerted by researchers, most of whom were affiliated with academic institutions. In most cases, the response of researchers was to contact community leaders before beginning fieldwork, set up community advisory committees, and/or hire "indigenous" interviewers (Weiss 1974:20); few were the instances when communities were able to share control over how the studies were conducted or interpreted.[1]

The Theoretical and Ideological Content of Minority Community Mental Health Training

Two of the strongest criticisms of the training center's program were that it lacked a coherent theoretical framework and failed to demonstrate how its training could be used in practice. A number of attempts were made throughout the country in the 1970s to develop such theoretical frameworks and training models in minority community mental health (Wong 1983). One of

the most comprehensive was developed by the Asian American Community Mental Health Training Center (Kushida et al. 1976; Chikahisa et al. 1976) for Asians and Pacific Islanders. However, despite such creative attempts, the theory, training, and practice of minority community mental health remains largely unintegrated.

Some important psychological stresses that affect the mental health of all minority groups in American society—such as oppression, empowerment, exploitation, and cultural maintenance—have been identified.[2] Concepts derived from the cultural heritages of specific groups that have a unique importance to their mental health have also been examined in recent research. For example the Japanese cultural value of *gaman* (self-control, patience, and endurance) can often prevent an individual from seeking early outside relief from troubling thoughts or other symptoms of mental distress (Yoshioka, Tashima, and Chew 1981:1-20). Other uniquely Japanese values such as *enryo* (restraint, hesitancy, and the desire not to be burdensome), *haji* (disgrace, dishonor, and shame), and *giri* (reciprocal obligation) have also been identified as potential barriers to the use of nontraditional community mental health facilities.

Research indicates that such cultural factors and concepts may affect the mental health and service utilization of other Pacific/Asian groups (D. Sue 1977; Sue, Sue, and Sue 1975; Sue and McKinney 1975; Yamamoto 1978a, 1978b) and other non-Asian minorities as well. For example, a number of values derived from Hispanic cultures, such as *respecto* (respect), *verguenza* (shame), and *deber de los hijos* (a social and moral obligation to support aged parents), have been used to explain certain aspects of social behavior and mental health (see, for example, Korte 1981).

While the usefulness of these and other theoretical concepts to training and practice has been shown, a systematic integration of theory, training, and practice has not advanced very far. Theoretical concepts provide only a partial and fragmented understanding of some aspects of minority community mental health. But, like characters in search of an author, they need to be integrated into a coherent theoretical perspective.[3]

The state of the art in the minority community mental health theory parallels that in the field of social work (Montiel and Wong 1983, n.d.; Wong 1982, 1983). Many publications in both these fields have been largely concerned with advocating and providing ideological justification for a larger minority share in resource allocation. Success in obtaining grants has become, in some circles, the ultimate goal. A deeper ideological and political analysis of the impact of social work and community mental health on minorities has never been done. In fact, some minority community mental health specialists and social workers have become mere "gatekeepers," speaking for the

working and lower classes in minority communities while acting as a buffer between them and the centers of political power. They see themselves as agents of change but are in reality part of the structure of social control created through the war on poverty programs. As the Brazilian educator Paulo Freire observed (1973:110):

> If a social worker (in the broadest sense) supposes that s/he is "*the* agent of change," it is with difficulty that s/he will see the obvious fact that, if the task is to be really educational and liberating, those with whom s/he works cannot be the objects of her actions. Rather, they too will be agents of change. If social workers cannot perceive this, they will succeed only in manipulating, steering and "domesticating." If, on the other hand, they recognize others, as well as themselves, as agents of change, they will cease to have the exclusive title of "*the* agent of change."

An examination of the history of the training center reveals exactly the paternalistic attitude that Freire cautions against. It was largely unsuccessful in recruiting nonprofessional community people to serve on its council and committees. Student recruitment was focused on the higher professional levels. In terms of ideological perspective, its training reinforced the importance of the professional expert in community mental health, while giving little attention to the participation of lay members from the community.[4]

Training for What? A Reexamination of the Goals of the Community Mental Health Movement

This story cannot end without a reexamination of the goals of the community mental health movement, for ultimately, training must be based on such goals. The question is, what was the main goal of the community mental health movement, social change or social control?

Scull's *Decarceration: Community Treatment and the Deviant* (1977) provides important evidence that the community mental health movement was merely an attempt by the state to alter the form of social control over the mentally ill in order to reduce social-program expenditures. Scull argues that the shift in the past twenty years, from locking "the mad and the bad" (the mentally ill and criminals) in total-care institutions to releasing them in the care of their communities—though presented as an essentially beneficent reform—is actually a purely practical response to fiscal crises (O'Conner 1973; Gough 1980).

In examining the history of the mental health field, Scull places its emergence as a profession in the nineteenth century (1977:17). Until the sixteenth century, care of the mentally ill was provided mainly by the family. At that

point, institutions for problem populations—the poor, the aged and infirm, lunatics, the sick and physically handicapped, vagrants and beggars, and minor criminals—began to appear. By the late nineteenth century, both England and America were abandoning this method of handling problem populations and moving increasingly toward institutionally based control systems (Scull 1977:21). Specialized institutions for separate types of problem populations were developing; this specialization brought with it the beginning of the professionalization of mental health, penology, and related fields, and with this professionalization came the need for training. Pioneers in the newly professional field of mental health wisely connected themselves to medicine in order to derive legitimacy from it.

All of this—the adoption of a medical model for the treatment of mental illness and the training of professionals; the ascendancy of specialized, segregated institutions (insane asylums); and the development of administrative procedures—took place in the nineteenth century. Despite a number of attempts at reform, the field remained unchanged until the 1950s. Furthermore, as Scull shows, the shift to the community mental health model that occurred in the 1960s came about before there was any substantial evidence on the validity of this new model.

Although some theoretical work on or related to community mental health had been published by the 1950s, as noted in Chapter 1, the definition of the field of community mental health was just being developed at that time. In fact, the parameters of this approach were first published as late as 1965, in the founding issue of the *Community Mental Health Journal* (Roen 1965:2). There was a great deal of ignorance about what community treatment actually involved and about the effects of abandoning institutional controls (Scull 1977:1). Yet, as Scull has shown, the trend toward decarcerating patients from mental hospitals was already well established by that year. The number of resident patients in state and county mental hospitals in the United States, which reached a high of 548,600 in 1957, was reduced to 215,600 by 1974 (Scull 1977:68). In terms of facilities, the break with the past was dramatically sudden, with transfers and ward closures sometimes ordered literally overnight (Scull 1977:69). In Wisconsin, for example, new legislation authorizing an 80 percent reduction of psychiatric beds in the state's 35 county hospitals produced a 77 percent decline in inpatient population during fiscal year 1974 (Scull 1977:69).

The decrease in the number of mental hospital residents since the mid-1950s has been accompanied by a steep rise in overall admission rates, reflecting a policy of greatly accelerated discharge (Scull 1977:67). This trend has, in turn, provided justification for abandoning expensive schemes to extend and/or renovate existing mental hospitals (Scull 1977:71).

In the 1950s, a medical justification for releasing the mentally ill to the care of the community was found in social science research. Studies showed the dehumanizing effects of total-care institutions and of labeling people as mentally ill (Goffman 1962, 1963; Scheff 1966). The field of medicine was also helpful in demonstrating the effectiveness of new pharmaceutical drugs in controlling the behavior of the mentally ill.

Erving Goffman's work on total-care institutions has probably had more impact on public mental health policies than any other research. In a nutshell, Goffman argues that the pathology of many institutionalized mental health patients has been caused primarily by the negative effects of total institutional care (Goffman 1962; Scull 1977:96).

Based on this research, it was assumed that patients restored to their communities would soon lose many of the pathological symptoms that had been caused by their institutionalization. However, the release of large numbers of patients to the care of neighborhood facilities was actually done without much prior collection and analysis of data about the likely effect of this move.

Scull's theory is that the community mental health movement was officially induced by the state in order to gain legitimacy and mass support for the shift from one form of social control to another.[5] His analysis merits serious attention. It obviously has important implications for any analysis of community mental health training, including the programs established in minority communities by NIMH in the 1960s and 1970s.

Certain changes in the past few years give added credibility to Scull's argument that the government's fiscal crisis and its need to cut social expenditures were the main impetus behind the community mental health movement. Now that further federal cuts have led to the closing of community mental health centers, traditional support systems, folk-healing methods, and social networks have gained a certain amount of currency in community mental health literature; they are being promoted as allegedly more effective, and definitely less costly, alternatives to professional care of the mentally ill.

A question of more than mere scholarly interest is, Are we beginning to experience a second major shift in mental health policy? We have gone from supporting mental asylums to supporting the community mental health approach. Now we may be moving away from community mental health as it has developed in the past two decades to an emphasis on the role of the family (in its various forms), self-help groups, and traditional healing methods. In their totality, these approaches shift the burden of mental health care even further away from the state.[6]

As Chapters 1 and 2 of this book indicated, minority communities did not accept the community mental health movement without criticism. A number of confrontations have taken place in the past two decades between such

communities and the state over research, training, and service delivery. The establishment of the Coastal Community Mental Health Training Center, for example, was preceded by serious protests in Pacific/Asian communities over federal mental health policies. As far as minority communities were concerned, the community mental health movement involved more than the removal of the severely disturbed from mental hospitals to community facilities. It was seen as part of the struggle for democratic rights, including access to education, job opportunities, housing, health care, and political participation.

While the state may have initiated the community mental health movement as a means of reducing social expenditures, minority communities supported it largely because it promised to extend mental health care to social and economic groups that had not previously been able to afford it. It was this vaguely defined promise that mental health care would be provided by the state in a variety of forms (not just in insane asylums) to the broad range of the mentally and emotionally disturbed (not only to those who were severely deranged) that propelled minorities to accept the movement.[7]

Many minority group members who had been civil rights activists in their communities were idealistically drawn into the community mental health movement. The movement, in turn, provided the opportunity for some to obtain professional training and enter the mental health profession. When a sizeable number had gained professional status in the field, organizations and coalitions were formed to promote their interests. Research indicated the superiority of ethnic treatment modalities over "color-blind" modalities and demonstrated the underutilization of mental health services by minority groups; however, empirical research was limited in scope and method. Much of it consisted of evaluations of particular agencies and programs such as this one. A systematic historical analysis of the impact of the community mental health movement on minority communities remains to be done.

The analysis of the Coastal Community Mental Health Training Center experience reveals how initial idealism and hopes were dissipated. However, the difficulties encountered by the training center cannot be attributed only to the problems which occurred within the center itself. It is also important to recognize how larger social, political, and economic forces shaped the center and partially determined its destiny.

Notes

1. For a further discussion of the problematic relationship between academic institutions and minority communities, see Bengston et al. 1977 and Moore 1977.

2. For an interesting application of these theoretical concepts in clinical practice, see Lum 1982.

3. There have been few serious attempts at theoretical integration. The paper by Korte (1981) is a notable exception. Korte considers the utility of a number of theoretical perspectives in explaining mental health among Mexican elders, including the possibility of linking macrotheoretical perspectives such as modernization theory with microlevel perspectives such as symbolic interactionism. See also Montiel 1981.

4. The domination of professionals, especially in the traditional medical fields and in community mental health at both the national and local levels, has also been observed by other researchers. See, for example, Castel, Castel, and Lovell 1982:124-169.

5. There have not been enough studies on social movements offically induced by the state or utilized by the state for control. For some thoughts on these issues, see Marx 1982. Existing theories of social movements may be conceptually inadequate for the analysis of movements induced by the state. For example, these theories generally conceive of social movement activity as unconventional or noninstitutionalized; that is, as standing outside the institutionalized framework of society. See Wood and Jackson 1982:3-13.

6. On the tension between the family and the state in social policy and welfare provisions, see the studies by Moroney 1976, 1980.

7. For discussions on Pacific/Asian perceptions of mental health care, see Sue and McKinney 1975. See also Murase 1977a, and Brown et al. 1973.

Appendix 1
Coastal Community Mental Health Training Council Bylaws

ARTICLE I: Name

Section 1 The name of this organization shall be the Coastal Community Mental Health Training Council; for the purpose of writing these bylaws, herein referred to as the Council.

ARTICLE II: Objectives

Section 1 The objectives of the Council shall be:

a. To organize and sustain a continuing program of education in the field for Asian American and Pacific Islander students through the development of community based training centers;
b. To recruit and financially support Asian American and Pacific Islander students for the social work fields and to familiarize these students with the commonalities and differences among the various Pacific/Asian communities;
c. To compile and make available information useful to Pacific/Asian communities in the [Coastal] area;
d. To identify and support legislation and various social issues at the federal, state, and local levels to improve the social conditions of the Pacific/Asian communities in the [Coastal] area;
e. To develop linkages between Asian American and Pacific Islander communities and educational institutions for their mutual benefit;
f. To do all other things necessary and appropriate for the advancement of these objectives.

ARTICLE III: Members

Section 1 Membership shall reflect a representation of (1) existing and emerging Asian American and Pacific Islander communities; (2) Asian American and Pacific Islander students from participating schools; and (3) participating educational institutions located in the [Coastal] region, within functional reason.

Section II The constituency of each category above shall determine the selection process of representation.

Section III The number of Council members shall be at least nineteen (19) and not more than twenty-five (25), with community representatives comprising at least 51 percent of the Council seats.

Section IV The term of membership for all Council members shall be two (2) years. However, for the first year of operation, there shall be two terms of membership: one half shall serve for one year, while the other half for two (2) years.

Section V Newly elected Council members will assume their membership immediately following the meeting of their election.

Section VI The process for replacement of members who vacate during their term:

a. Any person may come before the Council and apply for membership;

b. Applicants for membership shall be screened by the Council. Any applicant receiving 2/3 positive vote from the Council present shall be made a member.

Section VII Members failing to attend regular Council and standing committee meetings will be subject to removal after three (3) consecutive unexcused absences from either Council or standing committee meetings of which they are a member.

ARTICLE IV: Duties of the Council

Section I The purpose of the Council shall be to oversee the Center as a support system for the development of social service workers who will provide useful and fitting services to Asian American and Pacific Islander communities, specifically in the [Coastal] area.

Section II Council may adopt, repeal, and amend policies and procedures to increase its effectiveness and efficiency within the scope of its objectives.

Section III Council may hire and fire such persons as it deems necessary for the implementation and advancement of its objectives and purposes according to the established personnel procedure.

Section IV Each Council member shall be required to participate on at least one of the standing committees.

ARTICLE V: Standing Committees

Section I There shall be the following standing committees: Program, Personnel, Student Matters, Finance, and Policy and Procedures.

Section II Standing committees shall be composed of at least three (3)

Council members.

Section III Duties: Standing Committees are responsible for making recommendations to the Council in the following areas:

a. *Program Committee* shall work with the staff in the (1) creation and (2) evaluation of programs;

b. *Personnel Committee* shall be responsible for the soliciting, investigating, and evaluating all applicants for regular employment and shall be making recommendations on such applicants to the Council. It shall also be responsible for the formulation of all policy related with personnel matters, as well as the annual evaluation of staff;

c. *Student Matters Committee* shall be responsible for the (1) formulation of the student selection policy, (2) formulation of student grievance policy, (3) soliciting, investigating, and promoting matters particularly related to the student's welfare;

d. *Finance Committee* shall be responsible for the formulation of finance policies, all matters relating to the budget, and seek additional funding, if necessary;

e. *Policy and Procedures Committee* shall be responsible for the formulation, review, and revision of all general policies and procedures not covered by the other standing committees. It shall assume the responsibility for setting up the nomination and election of officers.

All recommendations of the standing committees are subject to the final approval of the Council.

Section IV Standing committees shall meet and report to the Council at least four times a year.

Section V Appropriate records of all committee meetings shall be kept on file at the Center.

ARTICLE VI: Election of Officers

Section I All elections of Officers at an annual meeting shall be by secret ballot.

Section II The Officers shall be elected by majority vote.

Section III In the event of failure to elect any Office by majority vote, further balloting on that office shall continue until a majority vote has been attained.

Section IV Term of office shall be one year with no one person holding the same office for two (2) consecutive terms.

Section V Term of office for newly elected officers shall begin immediately following the meeting of their election.

ARTICLE VII: Officers

Section I The Officers of the Council shall be a Chairperson and a Vice-Chairperson.

Section II The Chairperson shall preside at all meetings of the Council. The Chairperson may appoint special committees with the consent of the Council. The Chairperson shall be ex-officio member of all the committees.

Section III The Vice-Chairperson shall perform such duties as may be assigned by the Chairperson of the Council. In the absence of or disability of the Chairperson, the Vice-Chairperson shall perform all the duties of the Chairperson.

ARTICLE VIII: Meetings

Section I The Council will meet at least once a month.

Section II Special meetings may be called by the Chairperson or Project Director with consensus of three (3) Council members, provided all members are notified at least twenty-four (24) hours in advance of such meeting.

Section III Notice of all Committee and Council meetings shall be made to all Council members at least five (5) working days in advance as to time and any policy matters to be voted on location.

Section IV All monthly Council meetings are open to the public.

Section V Only members present at meeting may vote.

Section VI The Annual Meeting of the Council shall be called in January for the purpose of selection/election of new members and election of officers.

ARTICLE IX: Parliamentary Authority

Section I The rules contained in Robert's Rules of Order, Revised, shall be the parliamentary authority in all cases not covered by these bylaws.

ARTICLE X: Amendments to Bylaws

Section I These bylaws may be amended, adopted, or replaced at any regular or special meeting by at least a 60 percent majority vote of the Council members present, provided notice including the subject of the proposition (adoption, repeal, or amendment thereof) has been given in the call for the meeting.

As Adopted by the Council:
September 2, 1976

As Amended:
January 6, 1977

Appendix 2
Intensive Interview Schedule

Instructions to Interviewer

This schedule should be used in interviewing selected council and staff members, fieldwork supervisors, as well as knowledgeable community people. This schedule is a basic guide. Free "probes" should be pursued in instances when a respondent wants to or is able to elaborate upon a particular question at greater length. Responses to the questions should be recorded as close to verbatim as possible taking into account the time availability of the respondents.

The main purpose of the intensive interview is to gather in-depth information on various aspects of the performance of the training center. This information will complement the two statistical surveys. The second purpose of the intensive interview is to explore a number of issue areas in which our present understanding is limited. In most cases, the respondents are "expert informants" about the training center and problems in Asian American communities.

The interview should last approximately one to one and a half hours. Be sure to tell the respondent that the answers will be kept strictly confidential.

Interview Schedule

1. Looking at the development of the training center in the past four years, what do you think have been the main accomplishments and failures? Have the goals of the training center been achieved? (Please be specific.)

2. Has the training center provided training for social work students not available in college or in the community? What is your opinion of the quality of the training? How could it have been done better?

3. What impact has the training center had on Asian American communities in general and Asian American mental health in particular? How well has the training center met the needs of the communities in terms of mental health training? How could the impact have been greater?

4. In your estimate, how is the training center regarded in Asian American communities? How is the relationship between the training center and various

community organizations as well as social work agencies? How could the relationship have been improved?

5. How are the problems and needs of each Asian American community represented by the training center? If they are not represented, how could it have been improved?

6. What impact has the training center had on the departments of social work in colleges? How could the impact have been greater (e.g., curriculum, faculty hiring, research, etc.)?

7. How supportive have the colleges been to the training center? In what areas did they give support? In what areas did they not? How could the relationship between the training center and the colleges have been better? What efforts were exerted by each side to improve the relationship?

8. To your knowledge, after they finished their training at the training center, how prepared were the stipend students to do social work in general and mental health work in particular in Asian American communities?

9. What is your assessment of the enthusiasm and commitment of the stipend students to Asian American communities? How did the stipend students compare to other college students doing fieldwork in the communities?

10. What qualifications and background would you look for in the selection of stipend students? Do you feel that the training center used similar or different criteria? Please elaborate.

11. What is your assessment of the past and present staff of the training center in general? Has the staff met your expectations as far as roles and responsibilities are concerned? What areas need improvement?

12. In your assessment, what were the main strengths and weaknesses of individual staff members (past and present)? Were the strengths utilized properly? Were concrete actions taken to overcome the weaknesses? What kinds of training should have been given to individual staff members and as a group?

13. What kinds of curriculum materials on Asian American mental health should be developed by the training center? How should these materials be used and disseminated?

14. What is your assessment of the seminars given by the training center? Should other types of workshop and training seminars have been offered?

15. What is your overall assessment of the performance of the training center council? In what ways has the council contributed to the training center (e.g., staff training or development, student training and counselling, ties between community and Center)? In your opinion, what have been the strengths and weaknesses of the council in the past four years?

16. How has the relationship between the council and the staff been in the past four years? What are the problem areas in this relationship? How could they be resolved?

17. Overall, do you feel that the establishment of the training center has been worthwhile? Have the achievements justified the funding? Have the priorities for expenditures been correct? Have your expectations about the Center been met?

18. Is there any particular area(s) in the performance and functioning of the training center that the Evaluation Staff should pay special attention to?

19. Do you have any further comments about the training center or questions about the evaluation?

Appendix 3
Survey of Former Stipend Students

Background

First of all, we want some information about your background for statistical purposes.

1. Your age _____ (years)
2. Your sex

(1) _____ male
(2) _____ female

3. Your marital status

(1) _____ married
(2) _____ single
(3) _____ divorced or separated
(4) _____ widowed

4. To which of the following ethnic or nationality groups do you belong?

(1) _____ Cambodian
(2) _____ Chinese
(3) _____ Pilipino
(4) _____ Japanese
(5) _____ Korean
(6) _____ Samoan
(7) _____ Thai
(8) _____ Vietnamese
(9) _____ Other (specify) _____

5. What is your status in America?

(1) _____ U.S. citizen born in this country
(2) _____ naturalized U.S. citizen
(3) _____ permanent resident
(4) _____ refugee

6. How long have you been in the U.S.?

(1) _____ 0–1 year
(2) _____ 2–5 years
(3) _____ 6 or more years

Current Status

The following questions are designed to find out some information about or related to your present employment situation.

7. What degree(s) do you presently hold?

Degree	When did you receive it?	Where did you receive it?
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Are you currently: (please check the appropriate category)

(1) _____ working full-time in the field of social work
(2) _____ working part-time in the field of social work
(3) _____ working in an unrelated field
(4) _____ unable to find a job
(5) _____ not working by choice
(6) _____ continuing your education in social work
(7) _____ continuing your education in another field (please specify)

IF YOU ARE NOT WORKING, GO TO QUESTION 19.

9. How much contact do you have with Asian clients in your present job?

(1) _____ over 75% of the time
(2) _____ 50 to 75% of the time
(3) _____ 25 to 49% of the time
(4) _____ less than 25% of the time

10. Where are you presently working? (Give name of agency and address.)

_____

_____

11. Which of the following fields of practice occupies most of your time? (Check one category only.)

(01) _____ services to children
(02) _____ corrections
(03) _____ school of social work
(04) _____ mental illness
(05) _____ medical social work
(06) _____ services to families
(07) _____ research
(08) _____ developmentally disabled
(09) _____ services to aged
(10) _____ community organization and social planning
(11) _____ public welfare
(12) _____ community mental health
(13) _____ administration
(14) _____ other (please specify) _____

12. Which major activities do you perform in your current job? (Check as many as are applicable.)

(01) _____ direct service to individual clients
(02) _____ direct service to groups of unrelated clients
(03) _____ direct service to clients meeting in family groups
(04) _____ acting as a client advocate
(05) _____ staff development and training
(06) _____ supervising other staff members
(07) _____ offering consultation to other staff members
(08) _____ attending staff meetings
(09) _____ budgeting/financial planning
(10) _____ writing proposals for funding
(11) _____ fund raising
(12) _____ planning and carrying out research
(13) _____ writing (reports, papers, articles, etc.)
(14) _____ helping to develop new programs
(15) _____ offering consultation to other agencies
(16) _____ meeting with representatives of community agencies
(17) _____ organizing community groups
(18) _____ meeting with community groups
(19) _____ meeting with public officials
(20) _____ teaching
(21) _____ service to caretakers (e.g., foster parents, teachers, ministers, etc.)
(22) _____ other (please specify) _____

13. Which of the major activities you checked in question 12 would you rank as the most time-consuming aspect of your current job? Enter the number of the task from question 12: _____

14. How many hours of supervision, consultation, or staff development training per week would you say you receive in your current job?

(1) _____ none (3) _____ two hours
(2) _____ one hour (4) _____ over two hours

15. Do you supervise anyone who is performing social work activities in your current job?

(1) _____ yes (2) _____ no (Please go to question 18)

16. How many such persons do you supervise? (Enter number) _____

17. Of those persons supervised, how many:

(1) _____ have MSWs
(2) _____ do not have MSWs
(3) _____ are MSW students
(4) _____ other (please specify) _____

18. What is your current salary? (If part-time, transform into full-time rate.)

(1) _____ under $7,999
(2) _____ $8,000–8,999
(3) _____ $9,000–9,999
(4) _____ $10,000–11,999
(5) _____ $12,000–13,999
(6) _____ $14,000–15,999
(7) _____ $16,000–17,999
(8) _____ $18,000 and above

Training Center

In the following questions, we want to find out about your experience as a stipend student at the training center.

19. In what year did you recieve a stipend at the training center?

(1) _____ 1975–76
(2) _____ 1976–77
(3) _____ 1977–78
(4) _____ 1978–79

20. How did you hear about the training center?

21. When you were a stipend student at the training center, where were you going to school?

(1) _____ (Community College A)
(2) _____ (Community College B)
(3) _____ (Community College C)
(4) _____ (University A)
(5) _____ (University B)

22. When you were a stipend student at the training center, what degree were you working toward?

(1) _____ AA (3) _____ MSW
(2) _____ BA or BSW (4) _____ other (specify) _____

23. At the time when you applied for a student stipend, how much working and voluntary experience did you have in Asian American communities?

	Working	Voluntary
(1) 0–1 year	_____	_____
(2) 2–3 years	_____	_____
(3) 4–5 years	_____	_____
(4) 6 years or more	_____	_____

24. At the time when you applied for a student stipend, what was your cumulative grade point average?

(1) _____ below 2.00 (3) _____ 3.01–3.49
(2) _____ 2.00–3.00 (4) _____ 3.50 or above

25. As a stipend student, where were you placed in your fieldwork? (Put down the name of the agency for all field placements.)

_____

_____

26. Would you rather have been placed in another agency or setting in your fieldwork?

(1) _____ yes (2) _____ no

26a. If YES, where would you rather have been placed?

26b. Why would you have preferred that field placement?

27. As a stipend student, which of the following field(s) of practice were you placed in? (Check as many as applicable.)

(01) _____ services to children
(02) _____ corrections
(03) _____ school of social work
(04) _____ mental illness
(05) _____ medical social work
(06) _____ services to families
(07) _____ research
(08) _____ developmentally disabled
(09) _____ services to aged
(10) _____ community organization and social planning
(11) _____ public welfare
(12) _____ community mental health
(13) _____ administration
(14) _____ other (please specify) _____

28. As a stipend student, what major activities did you perform in your field placement(s)? (Check as many as are applicable.)

(01) _____ direct service to individual clients
(02) _____ direct service to groups of unrelated clients
(03) _____ direct service to clients meeting in family groups
(04) _____ acting as a client advocate
(05) _____ staff development and training
(06) _____ supervising other staff members
(07) _____ offering consultation to other staff members
(08) _____ attending staff meetings
(09) _____ budgeting/financial planning
(10) _____ writing proposals for funding
(11) _____ fund raising
(12) _____ planning and carrying out research
(13) _____ writing (reports, papers, articles, etc.)
(14) _____ helping to develop new programs
(15) _____ offering consultation to other agencies
(16) _____ meeting with representatives of community agencies
(17) _____ organizing community groups
(18) _____ meeting with community groups
(19) _____ meeting with public officials
(20) _____ teaching
(21) _____ service to caretakers (e.g., foster parents, teachers, ministers, etc.)
(22) _____ other (please specify) _____

29. Which of the major activities you checked in question 28 would you rank as the most time-consuming aspect of your current fieldwork? Enter the number of the task from question 28: _____

30. How satisfied were you with the role played by the fieldwork coordinator of the training center in your fieldwork?

(1) _____ very satisfied
(2) _____ mostly satisfied
(3) _____ somewhat satisfied
(4) _____ somewhat dissatisfied
(5) _____ mostly dissatisfied
(6) _____ very dissatisfied

31. How could the role of the fieldwork coordinator at the training center in your fieldwork have been improved?

32. How satisfied were you with your fieldwork supervisor at the agency(s) where you were placed?

(1) _____ very satisfied
(2) _____ mostly satisfied
(3) _____ somewhat satisfied
(4) _____ somewhat dissatisfied
(5) _____ mostly dissatisfied
(6) _____ very dissatisfied

33. How could the role of your fieldwork supervisor(s) at the agency(s) have been improved?

34. How satisfied were you with the role played by the fieldwork liaison person from your school?

(1) _____ very satisfied
(2) _____ mostly satisfied
(3) _____ somewhat satisfied
(4) _____ somewhat dissatisfied
(5) _____ mostly dissatisfied
(6) _____ very dissatisfied

35. How could the role of the fieldwork liaison person from your school have been improved?

36. On the average, how many hours of fieldwork supervision per week did you receive from each of the following persons?

Hours/week	Coordinator of Training Center	Liaison from School	Supervisor at Agency
1) 0–2	_____	_____	_____
2) 3–5	_____	_____	_____
3) 6–10	_____	_____	_____
4) 11 or more	_____	_____	_____

37. How satisfied were you with the seminars conducted by the training center?

38. How could the seminars have been improved?

39. How helpful to you were the following curriculum areas and courses offered at your college when you were a stipend student at the training center? (Leave blank any curriculum areas or courses not offered.)

	Very Helpful				Not at all Helpful
Field instruction in general	5	4	3	2	1
Classes in general	5	4	3	2	1
Practice methods courses in general	5	4	3	2	1
Growth and development courses	5	4	3	2	1
Social welfare policy courses	5	4	3	2	1
Research courses	5	4	3	2	1
Elective courses in social welfare in general	5	4	3	2	1
Other elective courses	5	4	3	2	1
School experience in general	5	4	3	2	1

40. Did students have the opportunity to make contributions to the training center?

(1) _____ many opportunities
(2) _____ some opportunities
(3) _____ little or no opportunity

What were the opportunities? (If no opportunity, leave blank.)

41. If you had not received a stipend from the training center, would you still have enrolled in the same program in school?

(1) _____ yes
(2) _____ no
(3) _____ not sure

42. Has your involvement in Asian American communities increased or decreased after the end of your stipend period at the training center?

(1) _____ increased significantly
(2) _____ increased somewhat
(3) _____ remained about the same
(4) _____ decreased slightly
(5) _____ decreased significantly

43. How well did your experience at the training center prepare you for professional social work in Asian American communities?

(1) _____ very well
(2) _____ fairly well
(3) _____ fairly poorly
(4) _____ very poorly

43a. What were the most valuable experiences that you gained at the training center?

43b. Do you think you could have gotten these experiences some other way if you were not a stipend student at the training center?
(1) _____ yes (2) _____ no

44. What else could the training center have done to improve the training of the students for professional social work in Asian American communities?

Thank you for your cooperation. Be sure to put the completed questionnaire in the self-addressed stamped envelope and mail it to us at your earliest convenience.

Appendix 4
Program Evaluation Questionnaire

Background

First of all, we want some information about your background for statistical purposes.

1. Are you (please check as many as are applicable):

(1) _____ a former council member of the training center
(2) _____ a current council member
(3) _____ a former fieldwork supervisor of the stipend students of the training center
(4) _____ a current fieldwork supervisor
(5) _____ a former staff member
(6) _____ a current staff member
(7) _____ a faculty member in a school of social work
(8) _____ none of the above

IF YOUR ANSWER IS NONE OF THE ABOVE TO QUESTION 1, DO NOT FILL OUT THIS QUESTIONNAIRE. PLEASE RETURN IT TO US IN THE SELF-ADDRESSED ENVELOPE.

2. How long have you been associated with the training center?

(1) _____ less than 1 year
(2) _____ between 1 to 2 years
(3) _____ between 2 to 3 years
(4) _____ between 3 to 4 years
(5) _____ more than 4 years

3. Your age _____ (years)

4. Your sex

(1) _____ male
(2) _____ female

5. Your marital status

(1) _____ married
(2) _____ single
(3) _____ divorced or separated
(4) _____ widowed

6. To which of the following ethnic or nationality groups do you belong?

(1) _____ Cambodian
(2) _____ Chinese
(3) _____ Pilipino
(4) _____ Japanese
(5) _____ Korean
(6) _____ Samoan
(7) _____ Thai
(8) _____ Vietnamese
(9) _____ Other (specify) _____

7. What is your status in America?

(1) _____ U.S. citizen born in this country
(2) _____ naturalized U.S. citizen
(3) _____ permanent resident
(4) _____ refugee

8. How long have you been in the U.S.?

(1) _____ 0–1 year
(2) _____ 2–5 years
(3) _____ 6 or more years

Current Status

The following questions are designed to find out some information about or related to your present employment situation.

9. What degree(s) do you presently hold?

Degree	When did you receive it?	Where did you receive it?

10. What professional licenses or credentials do you hold?

(1) _____ FMCC
(2) _____ LCSW
(3) _____ ACSW
(4) _____ Other licenses (please specify) _____

11. Are you currently: (please check the appropriate category)

(1) _____ working full-time in the field of social work
(2) _____ working part-time in the field of social work
(3) _____ working in an unrelated field
(4) _____ unable to find a job
(5) _____ not working by choice
(6) _____ continuing your education in social work
(7) _____ continuing your education in another field (please specify)

IF YOU ARE NOT WORKING, GO TO QUESTION 25.

12. What is the title of your position? _____

13. How much contact do you have with Asian clients in your present job?

(1) _____ over 75% of the time
(2) _____ 50 to 75% of the time
(3) _____ 25 to 49% of the time
(4) _____ less than 25% of the time

14. Where are you presently working? (Give name of agency and address.)

_____

_____

15. Which of the following fields of practice occupies most of your time? (Check one category only.)

(01) _____ services to children
(02) _____ corrections
(03) _____ school of social work
(04) _____ mental illness
(05) _____ medical social work
(06) _____ services to families
(07) _____ research
(08) _____ developmentally disabled
(09) _____ services to aged
(10) _____ community organization and social planning
(11) _____ public welfare
(12) _____ community mental health
(13) _____ administration
(14) _____ other (please specify) _____

16. Which major activities do you perform in your current job? (Check as many as are applicable.)

(01) _____ direct service to individual clients
(02) _____ direct service to groups of unrelated clients
(03) _____ direct service to clients meeting in family groups
(04) _____ acting as a client advocate
(05) _____ staff development and training
(06) _____ supervising other staff members
(07) _____ offering consultation to other staff members
(08) _____ attending staff meetings
(09) _____ budgeting/financial planning
(10) _____ writing proposals for funding
(11) _____ fund raising
(12) _____ planning and carrying out research
(13) _____ writing (reports, papers, articles, etc.)
(14) _____ helping to develop new programs
(15) _____ offering consultation to other agencies

(16) _____ meeting with representatives of community agencies
(17) _____ organizing community groups
(18) _____ meeting with community groups
(19) _____ meeting with public officials
(20) _____ teaching
(21) _____ service to caretakers (e.g., foster parents, teachers, ministers, etc.)
(22) _____ other (please specify) _____

17. Which of the major activities you checked in question 16 would you rank as the most time-consuming aspect of your current job? Enter the number of the task from question 16: _____

18. How many hours of supervision, consultation, or staff development training per week would you say you receive in your current job?

(1) _____ none
(2) _____ one hour
(3) _____ two hours
(4) _____ over two hours

19. Do you supervise anyone who is performing social work activities in your current job?

(1) _____ yes (2) _____ no (please go to question 23)

20. How many such persons do you supervise? (Enter number) _____

21. How long have you been in a supervisory position?

(1) _____ less than 1 year
(2) _____ from 1 to 3 years
(3) _____ from 4 to 6 years
(4) _____ 7 years or more

22. Of those persons supervised, how many:

(1) _____ have MSWs
(2) _____ do not have MSWs
(3) _____ are MSW students
(4) _____ other (please specify) _____

23. How well have you been able to keep abreast of the current literature and developments in your professional field?

(1) _____ very well
(2) _____ fairly well
(3) _____ fairly poorly
(4) _____ very poorly

24. What is your current salary? (If part-time, transform into full-time rate.)

(1) _____ under $7,999
(2) _____ $8,000–8,999
(3) _____ $9,000–9,999
(4) _____ $10,000–11,999
(5) _____ $12,000–13,999
(6) _____ $14,000–15,999
(7) _____ $16,000–17,999
(8) _____ $18,000 and above

Assessment of the Training Center

The following questions are designed to find out your assessment of the training center.

25. Looking at the development of the training center in the past four years or since you have been associated with it, how well have the following goals been met?

Goals	Very Well	Fairly Well	Fairly Poorly	Very Poorly
Provide training for Asians/Pacific Islanders entering the social work field	1	2	3	4
Recruit and select bilingual-bicultural social work students	1	2	3	4
Develop training materials and resources on the mental health of Asians/Pacific Islanders	1	2	3	4
Get the social work schools to recognize the needs of Asian/Pacific Islander communities	1	2	3	4
Get the social work schools to set up curriculum relevant to Asians/Pacific Islanders	1	2	3	4
Provide financial assistance to those students who otherwise would not be in school	1	2	3	4
Identify and support legislation affecting Asian/Pacific Islander communities	1	2	3	4
Provide opportunities for interethnic communication among students and community people	1	2	3	4
Provide community-oriented training	1	2	3	4
Act as a support group to Asian/Pacific Islander students	1	2	3	4
Organize social action in support of particular issues affecting Asians/Pacific Islanders	1	2	3	4
Act as advocate for the needs of Asians/Pacific Islanders	1	2	3	4
Other goals (please specify) _____ _____	1	2	3	4

26. Has the training center provided the training opportunities for social work students that are *not* available in the colleges or in the communities?

(1) _____ yes
(2) _____ no

27. Has the training offered by the training center improved over the past four years?

(1) _____ improved significantly
(2) _____ improved somewhat
(3) _____ remained about the same
(4) _____ deteriorated slightly
(5) _____ deteriorated significantly

28. How well has the training center served the needs of each Asian/Pacific Islander community?

Community	Very Well	Fairly Well	Fairly Poorly	Very Poorly
Cambodian	____	____	____	____
Chinese	____	____	____	____
Pilipino	____	____	____	____
Japanese	____	____	____	____
Korean	____	____	____	____
Samoan	____	____	____	____
Thai	____	____	____	____
Vietnamese	____	____	____	____
Other (specify) _____	____	____	____	____

29. In your opinion, do you feel that the training center has solicited and received sufficient imput from each Asian/Pacific Islander community?

Community	Yes	No	Don't Know
Cambodian	_____	_____	_____
Chinese	_____	_____	_____
Pilipino	_____	_____	_____
Japanese	_____	_____	_____
Korean	_____	_____	_____
Samoan	_____	_____	_____
Thai	_____	_____	_____
Vietnamese	_____	_____	_____
Other (specify) _____	_____	_____	_____

30. Do you feel that each Asian/Pacific Islander community has been fairly represented in the Training Center?

	Representation As							
	Stipend Students		Staff		Council Members		Fieldwork Supervisor	
Community	Yes	No	Yes	No	Yes	No	Yes	No
Cambodian	___	___	___	___	___	___	___	___
Chinese	___	___	___	___	___	___	___	___
Pilipino	___	___	___	___	___	___	___	___
Japanese	___	___	___	___	___	___	___	___
Korean	___	___	___	___	___	___	___	___
Samoan	___	___	___	___	___	___	___	___
Thai	___	___	___	___	___	___	___	___
Vietnamese	___	___	___	___	___	___	___	___
Other (specify) _____	___	___	___	___	___	___	___	___

31. What impact has the training center had on the schools of social work?

	Extent of Impact			
Areas of Impact	A Lot	Some	Little	None
Curriculum	___	___	___	___
Faculty/administrator (recruitment, promotion)	___	___	___	___
Student recruitment	___	___	___	___
School policies affecting Asian/Pacific Islanders	___	___	___	___
Linkages between community and schools	___	___	___	___
Other areas (please specify) _____	___	___	___	___

32. In your opinion, how supportive have the colleges been to the training center?

College	Highly Supportive	Somewhat Supportive	Somewhat Unsupportive	Highly Unsupportive
Univ. A	_____	_____	_____	_____
Univ. B	_____	_____	_____	_____
Col. A	_____	_____	_____	_____
Col. B	_____	_____	_____	_____
Col. C	_____	_____	_____	_____

33. How well has the training center served the needs of the different levels of students?

Level	Very Well	Fairly Well	Fairly Poorly	Very Poorly
AA students	____	____	____	____
BA students	____	____	____	____
MSW students	____	____	____	____

34. Do you agree with the policies and practices of student selection of the training center?

(1) _____ yes
(2) _____ no

If your opinion is no in Question 34, please explain.

35. Overall, how well has the staff been able to implement the goals of the training center?

(1) _____ very well
(2) _____ fairly well
(3) _____ fairly poorly
(4) _____ very poorly

36. Have you noticed any improvements in the ability of the staff to implement the goals of the training center in the past four years?

(1) _____ improved significantly
(2) _____ improved somewhat
(3) _____ remained about the same
(4) _____ deteriorated somewhat
(5) _____ deteriorated significantly

37. In your opinion, how well has the staff carried out the following activities?

Activity	Very Well	Fairly Well	Fairly Poorly	Very Poorly	No Opinion
Staff training and development	____	____	____	____	____
Staff supervision	____	____	____	____	____
Office management	____	____	____	____	____
Student field placements and supervision	____	____	____	____	____
Budgeting/financial planning	____	____	____	____	____
Proposal development, research, and planning	____	____	____	____	____
Report writing	____	____	____	____	____
Communication between staff and council	____	____	____	____	____
Communication between staff and community	____	____	____	____	____

Communication between staff and schools	___	___	___	___	___
Communication between staff and students	___	___	___	___	___
Communication between staff and other agencies	___	___	___	___	___
Other activities (please specify)	___	___	___	___	___

38. How satisfied were you with the performance of the Council in the following activities?

Activity	Degree of Satisfaction					
	Very Satis.	Mostly Satis.	Somewhat Satis.	Somewhat Dissat.	Mostly Dissat.	Very Dissat.
Program development (planning and evaluation of programs)	___	___	___	___	___	___
Personnel matters (hiring, evaluation of staff, personnel policies)	___	___	___	___	___	___
Student matters (selection, grievance procedures, promoting the welfare of students	___	___	___	___	___	___
Financial matters (finance policies, budget, solicitation of funds)	___	___	___	___	___	___
Policies and procedures (formulation of policies and procedures, election of officers)	___	___	___	___	___	___
Other (please specify	___	___	___	___	___	___

39. How has the relationship between the council and the staff been in the past four years or since you have been associated with the training center?

39a. What are the problem areas in this relationship?

39b. How could these problems be resolved?

40. In general, how satisfied are you with the training that stipend students received at the field placement?

(1) _____ very satisfied
(2) _____ mostly satisfied
(3) _____ somewhat satisfied
(4) _____ somewhat dissatisfied
(5) _____ mostly dissatisfied
(6) _____ very dissatisfied

40a. If you are dissatisfied, why?

41. Have you supervised any stipend student from the training center?

(1) _____ yes (2) _____ no

41a. If yes, how many? _____ (enter number)

IF YOUR ANSWER IS NO TO QUESTION 41, GO TO QUESTION 44.

42. Did your agency have a training program for stipend students from the training center and for other social work students?

(1) _____ yes
(2) _____ no

43. How would you rate the performance of the stipend students from the training center in comparison to other students in your agency?

(1) _____ training center students much better than other students
(2) _____ training center students somewhat better
(3) _____ training center students about the same as other students
(4) _____ training center students somewhat worse than other students
(5) _____ training center students much worse than other students
(6) _____ no basis for evaluation

44. How well has the training center prepared the stipend students for professional social work in Asian/Pacific Islander communities?

(1) _____ very well
(2) _____ fairly well
(3) _____ fairly poorly
(4) _____ very poorly

45. What else could the training center have done to improve the training of the students for professional social work in Asian/Pacific Islander communities?

46. Overall, do you feel that the establishment of the training center has been worthwhile?
(1) _____ yes
(2) _____ no
(3) _____ not sure

47. If funds could be obtained, would you support the continuation of the training center by and large in its present form?
(1) _____ yes
(2) _____ no
(3) _____ not sure

47a. If no or not sure, please explain.

48. How active would you say you have been in the work of the training center?
(1) _____ very active
(2) _____ fairly active
(3) _____ somewhat active
(4) _____ not very active

49. For former and present council members or fieldwork supervisors: About how many hours per month did you devote to the activities of the training center? (Leave blank if not applicable.)
(1) _____ 0–2 hours
(2) _____ 3–5 hours
(3) _____ 6–10 hours
(4) _____ 11–15 hours
(5) _____ more than 15 hours

50. Is there any particular area(s) in the performance and functioning of the training center that the evaluation staff should pay special attention to? (Please elaborate.)

Thank you for your cooperation. Be sure to put the completed questionnaire in the self-addressed stamped envelope and mail it to us at your earliest convenience.

References

Abad, Vicente, Juan Ramos, and Elizabeth Boyce

1974 A model for delivery of mental health services to Spanish-Speaking minorities. *American Journal of Orthopsychiatry* 44(4):584–595.

Bengston, Vern L., Eugene Grigsby, Elaine M. Corry, and Mary Hruby

1977 Relating academic research to community concerns: A case study in collaborative effort. *Journal of Social Issues* 33(4):75–92.

Binner, Paul

1973 Program evaluation. Pp. 342–383 in Saul Feldman (ed.), *Administration of mental health services*. Springfield, IL: Charles C. Thomas.

Bloom, Bernard L.

1977 *Community mental health: A general introduction*. Belmont, CA: Wadsworth Publishing Company.

Bonacich, Edna

1972 A theory of ethnic antagonism: The split labor market. *American Sociological Review* 37(October):547–559.

1976 Advanced capitalism and black/white race relations in the United States: A split labor market interpretation. *American Sociological Review* 41(February):34–51.

Bowles, Samuel, and Herbert Gintis

1976 *Schooling in capitalist America*. New York: Basic Books.

Brooks, Michael P.

1965 The community action program as a setting for applied research. *Journal of Social Issues* 21(1):29–40.

Brown, Timothy R., Kenneth M. Stein, Katherine Huang, and Darrel E. Harris

1973 Mental illness and the role of mental health facilities in Chinatown. Pp. 212–231 in Stanley Sue and Nathaniel N. Wagner (eds.), *Asian Americans: Psychological perspectives*. Palo Alto, CA: Science and Behavior Books.

Campbell, Donald T., and Julian C. Stanley
1966 *Experimental and quasi-experimental designs for research.* Chicago: Rand McNally.

Caplan, Gerald
1974 *Support systems and community mental health.* New York: Behavioral Publications.

Carmichael, Stokely S., and Charles V. Hamilton
1967 *Black power: The politics of liberation in America.* New York: Vintage Books.

Castel, Robert, Francoise Castel, and Ann Lovell
1982 The illusions of community. Pp. 124–169 in Robert Castel and Francoise Castel (eds.), *The psychiatric society.* New York: Columbia University Press.

Chikahisa, Paul, Kay Cho, Arlene Hori Kushida, and Royal F. Morales
1976 *Asian and Pacific American curriculum on social work education.* Los Angeles: Asian American Community Mental Health Training Center. Mimeographed.

Chu, Franklin, and Sharland Trotter
1974 *The madness establishment: Ralph Nader's study group report on the National Institute of Mental Health.* New York: Grossman.

Collins, Alice H., and Diane L. Pancoast
1976 *Natural helping networks: A strategy for prevention.* New York: National Association of Social Workers.

Cooper, E. Myles
1973 *Guidelines for a minimum statistical and accounting system for community mental health centers.* DHEW Publication No. (ADM)-74-14. Washington, D.C.: U.S. Government Printing Office.

Council on Social Work. Commission on Minority Groups. Ad Hoc Committee.
1973 Report on community participation. New York: CSWE. Mimeographed.

Coursey, Robert D.
1977 Introduction: The needs, history, definition and limits of program evaluation. Pp. 1–8 in Robert D. Coursey (ed.), *Program evaluation for mental health: Methods, strategies, and participants.* New York: Grune and Stratton, Inc.

Crawford, Jeffrey L., Donald W. Morgan, and Daniel T. Gianturco (eds.)
1974 *Progress in mental health information systems: Computer application.* Cambridge, MA: Ballinger.

Davidoff, Isabel, Marcia Guttentag, and Joan Offutt
1977 *Evaluating community mental health services: Principles and practice*. DHEW Publication No. (ADM) 77-465. Rockville, MD: National Institute of Mental Health.

Denham, William H.
1982 Federal trends in mental health manpower programs. Pp. 135–141 in Faye Untalan Munoz and Russell Endo (eds.), *Perspectives on minority group mental health*. Washington, D.C.: University Press of America.

Deutsch, Albert
1948 *The shame of the states*. New York: Harcourt Brace Jovanovich.

Durkheim, Emile
[1893] 1933 *The division of labor in society*. New York: Macmillan.
[1897] 1951 *Suicide*. Glencoe, IL: The Free Press.

Fanon, Frantz
1963 *The wretched of the earth*. New York: Grove Press.
1967 *Black skin, white masks*. New York: Grove Press.

Faris, Robert E., and H. Warren Dunham
1939 *Mental disorders in urban areas*. Chicago: University of Chicago Press.

Feldman, Saul, and Harold H. Goldstein
1971 Community mental health centers in the United States: An overview. *International Journal of Nursing Studies* 8:247–257.

Feldman, Saul, and Charles Windle
1973 The NIMH approach to evaluating the community mental health centers program. *Health Services Reports* 88(2):174–180.

Festinger, Leon, and Harold H. Kelley
1951 *Changing attitudes through social contact*. Ann Arbor: University of Michigan, Institute for Social Research.

Freire, Paulo
1973 *Education for critical consciousness*. New York: Seabury Press.

Garfinkel, Harold
1956 Conditions of successful degradation ceremonies. *American Journal of Sociology* 61(5,March):420–424.

Glock, Charles Y. (ed.)
1967 *Survey research in the social sciences*. New York: Russell Sage Foundation.

Goffman, Erving
1962 *Asylums: Essays on the social situation of mental patients and other inmates*. Chicago: Aldine.
1963 *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Goldstein, Irwin L.
1977 Evaluation of educational and training programs. Pp. 225–241 in *Program evaluation for mental health*. See Coursey 1977.

Gough, Ian
1979 *The political economy of the welfare state*. New York and London: Macmillan.

Grob, Gerald N. (ed.)
1979 *Historical issues in mental health series*. 45 volumes. New York: Arno Press.
1980 *Immigrants and insanity: Dissenting views, 1883–1914*. New York: Arno Press.

Gurel, Lee
1975 The human side of evaluating human service programs: Problems and prospects. Pp. 11–28 in Volume 2 of Marcia Guttentag and Elmer Struening (eds.), *Handbook of evaluation research*. Beverly Hills, CA: Sage.

Hardcastle, David A., and Arthur J. Katz
1979 *Employment and unemployment in social work: A study of NASW members*. Washington, D.C.: National Association of Social Workers.

Hirschowitz, R.G.
1970 An attempt to delineate the field of community psychiatry. *Hospital and Community Psychiatry* 21:209–212.

Hollingshead, August B., and Fredrick C. Redlich
1958 *Social class and mental illness: A community study*. New York: Wiley.

Isaac, Stephen, and William B. Michael
1981 *Handbook in research and evaluation*. Second edition. Ch. 1, pp. 1–31. San Diego: Edits Publishers.

Joint Commission on Mental Health and Illness
1961 *Action for mental health*. New York: Basic Books.

Jones, Maxwell
1953 *The therapeutic community*. New York: Basic Books.

Kaplan, Seymour R., and Melvin Roman
1973 *The organization and delivery of mental health services in the ghetto: The Lincoln Hospital experience*. New York: Praeger.

Kerr, Clark

1972 *The uses of the university*. Revised edition. Cambridge, MA: Harvard University Press.

Korte, Alvin O.

1981 Theoretical perspectives in mental health and the Mexicano elders. Pp. 1–37 in Manuel Miranda and Rene A. Ruiz (eds.), *Chicano aging and mental health*. DHHS Publication No. (ADM) 81-952. Rockville, MD: National Institute of Mental Health.

Kuramoto, Ford H.

1971 What do Asians want? An examination of issues in social work education. *Journal of Education for Social Work* 7(3, Fall):7–17.

1978 The President's Commission on Mental Health and national mental health programs in terms of minority response. Mimeographed.

Kushida, Arlene Hori, Marilyn Montenegro, Paul Chikahisa, and Royal F. Morales

1976 A training program for Asian and Pacific Islander Americans. *Social Casework* 57(3, March):185–194.

Landsberg, Gerald, William D. Neigher, Roni J. Hammer, Charles Windle, and J. Richard Woy

1979 *Evaluation in practice: A sourcebook of program evaluation studies from mental health care systems in the United States*. DHEW Publication No. (ADM) 78-763. Washington, D.C.: U.S. Government Printing Office.

Lazarsfeld, Paul F., William H. Sewell, and Harold L. Wilensky (eds.)

1967 *The uses of sociology*. New York: Basic Books.

Liu, William T., and Mariko Yamada

1976 The Asian American Mental Health Research Center. *Social Casework* 57(3, March):136–138.

Lum, Doman

n.d. First year report, Asian American Social Work Training Project. NIMH Grant No. 5T21 MH14186-02. School of Social Work, California State University, Sacramento, California. Mimeographed.

1982 Toward a framework for social work practice with minorities. *Social Work* 27(3, May):244–249.

Malzberg, Benjamin

[1940]. *1979* *Social and biological aspects of mental disease*. New York: Arno Press.

Marx, Gary T.

1982 External efforts to damage or facilitate social movements: Some

patterns, explanations, outcomes and complications. Pp. 181–200 in James L. Wood and Maurice Jackson (eds.), *Social movements: Development, participation and dynamics*. Belmont, CA: Wadsworth Publishing Co.

Maykovich, Minako Kurokawa

1977 The difficulties of a minority researcher in minority communities. *Journal of Social Issues* 33(4):108–119.

Mayo, Elton

1933 *The human problems of an industrial civilization*. New York: Macmillan.

Montero, Darrel, and Gene N. Levine (eds.)

1977 Research among racial and cultural minorities: Problems, prospects and pitfalls. *Journal of Social Issues* 33(4).

Montiel, Miguel

1981 Social research and the Chicano community. Pp. 212–237 in Manuel Miranda and Rene A. Ruiz (eds.), *Chicano aging and mental health*. DHHS Publication No. (ADM) 81–952. Rockville, MD: National Institute of Mental health.

Montiel, Miguel, and Paul Wong

1983 The minority perspective in social work: A theoretical critique. *Social Casework*, 62(February):112–117.

n.d. Theories of race relations and the minority perspective in social work. *Journal of Sociology and Social Welfare*, forthcoming.

Moore, Joan W.

1977 A case study of collaboration: The Chicano Pinto research project. *Journal of Social Issues* 33(4):144–158.

Moroney, Robert M.

1976 *The family and the state: Considerations for social policy*. London and New York: Longman.

1980 *Families, social services, and social policy: The issue of shared responsibility*. DHHS Publication No. (ADM) 80-846. Washington, D.C.: U.S. Government Printing Office.

Murase, Kenji

1973 *Asian American Task Force report: Problems and issues in social work education*, edited by Kenji Murase. New York: Council on Social Work Education.

1977a Minorities: Asian Americans. *Encyclopedia of Social Work*. Washington, D.C.: National Association of Social Work.

1977b Social work training programs—school controlled or community

controlled: An analysis of the Asian American experience. Mimeographed.

1978 Social welfare policy and services: Asian Americans. Pp. 34–48 in Dolores G. Norton (ed.), *The dual perspective: Inclusion of ethnic minority content in the social work curriculum*. New York: Council on Social Work Education.

1981 Issues and strategies in the delivery of mental health services to Asian/Pacific Americans. Paper presented at a symposium of the Asian Human Services Association, Denver, CO, May 8.

Musto, David F.

1975 Whatever happened to community mental health? *Public Interest* 39 (Spring):53–79.

Newman, John Henry, Cardinal

1947 *The idea of a university*. New York: Longmans Green.

National Institute of Mental Health (NIMH)

1974a *The first national conference on Asian American mental health*. DHEW Publication No. (ADM) 74-46. Rockville, MD: NIMH.

1974b *Resource materials for community mental health program evaluation, a workman's guide to the CMH program evaluation literature*. GPO 792-847/144.

1977 Provisional data on federally funded community mental health centers, 1975–1976. Unpublished memorandum. April. (Quoted in Segal, p. 185.)

O'Connor, James

1973 *The fiscal crisis of the state*. New York: St. Martin's Press.

Odegaard, O.

1932 *Emigration and insanity*. Copenhagen: Erin Munksgaard Publishers.

Pacific/Asian Elderly Research Project

1978 *Final report*. Los Angeles: P/AERP.

Padilla, Amado, Rene A. Ruiz, and Rodolfo Alvarez

1975 Community mental health services for the Spanish-speaking/surnamed population. *American Psychologist* 30(9,September):892–905.

Panzetta, Anthony F.

1971 *Community mental health: Myth and reality*. Philadelphia: Lea and Febiger.

Porter, William H.

1977 A management by objectives approach to program evaluation. Pp. 93–103 in *Program evaluation for mental health*. See Coursey 1977.

President's Commission on Mental Health

1978a Report of the Special Populations Subpanel on the mental health of American Indians and Alaska Natives. Pp. 952–998 in Vol. III of *Report to the President*. Washington, D.C.: U.S. Government Printing Office.

1978b Report of the Special Populations Subpanel on the mental health of Asian/Pacific Americans. Pp. 773–819 in Vol. III of *Report to the President*. Washington, D.C.: U.S. Government Printing Office.

Rapoport, Robert N., Rhona Rapoport, and Irving Rosow

[1960] 1979 *Community as doctor: New perspectives on a therapeutic community*. New York: Arno Press.

Riesman, David

1958 *Constraint and variety in American education*. Garden City, NY: Doubleday.

Roen, Sheldon R.

1965 Parameters of a community mental health approach. *Community Mental Health Journal* 1:2.

Rossi, Ascanio M.

1962 Some pre-World War II antecedents of community mental health theory and practice. *Mental Hygiene* 46:78–94.

Sanchez, Armand

1971 The definers and the defined: A mental health issue. *El Grito* 4(4, Summer):4–11.

Scheff, Thomas J.

1966 *Being mentally ill: A sociological theory*. Chicago:Aldine.

Scherman, Robert

1977 Will goal attainment scaling solve the problems of program evaluation in the mental health field? Pp. 105–118 in *Program evaluation for mental health*. See Coursey 1977.

Scull, Andrew T.

1977 *Decarceration: Community treatment and the deviant—a radical view*. Englewood Cliffs, NJ: Prentice-Hall.

Segal, Steven P.

1981 Community mental health. Pp. 168–189 in Neil Gilbert and Harry Specht (eds.), *Handbook of the social services*. Englewood Cliffs, NJ: Prentice-Hall.

Shaw, Robert, and Carol J. Eagle

1971 Programmed failure: The Lincoln Hospital story. *Community Mental*

Health Journal 7(4):255–263.

Southern Regional Education Board
1978 *Issues in black mental health.* Atlanta.

Srole, Leo, Thomas S. Langner, Stanley T. Michael, Marvin K. Opler, and Thomas A. C. Rennie
1962 *Mental health in the metropolis.* New York: McGraw-Hill.

Suchman, Edward A.
1967 *Evaluative research.* New York: Russell Sage Foundation.

Sue, Derald W.
1977 Counseling the culturally different: A conceptual analysis. *Personnel and Guidance Journal* 55(7, March):422–425.

Sue, Stanley
1977 Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist* 32(8, August): 616–624.

Sue, Stanley, and Robert Chin
n.d. The National Asian American Psychology Training Conference, 1976. Conference report.

Sue, Stanley, and Herman McKinney
1975 Asian Americans in the community mental health care system. *American Journal of Orthopsychiatry* 45(1):111–118.

Sue, Stanley, Derald W. Sue, and David W. Sue
1975 Asian Americans as a minority group. *American Psychologist* 30(9, Sept.):906–910.

Szasz, Thomas S.
[1961] 1974 *The myth of mental illness: Foundations of a theory of personal conduct.* New York: Harper and Row.

U.S. Bureau of the Census
1981 *Census of population; Race of the population by states: 1980.* Report No. PC80-S1-3. Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Health, Education and Welfare. National Institute of Mental Health. *See* National Institute of Mental Health.

Veblen, Thorstein
1954 *The higher learning in America.* Stanford, CA: Academic Reprints.

Walton, Richard E.
1969 *Interpersonal peacemaking: Confrontations and third party consultation.* Reading, MA: Addison-Wesley.

Ward, Mary J.
1946 *The snake pit*. New York: Random House.

Weinstein, Marvin
1972 The role of trust in program evaluation: Some guidelines for the perplexed administrator. *Canadian Psychologist* 13:239-251.

Weiss, Melford S.
1974 *Valley City: A Chinese community in America*. Cambridge: Schenkman.
1977 The research experience in a Chinese-American community. *Journal of Social Issues* 33(4):120–132.

Wilder, Jack F., and Sutherland Miller
1973 Management information. Pp. 120–137 in Saul Feldman (ed.), *The administration of mental health services*. Springfield, IL: Charles C. Thomas.

Wong, Paul
1972 The emergence of the Asian American movement. *Bridge: The Magazine for Asians in America* 2(1, September/October):33–39.
1982 Social work research on minorities: Toward a comparative approach. *Journal of Education for Social Work*, 18:69–76.
1983 The evolution of the minority perspective in community mental health. Paper prepared for presentation at the Annual Program Meeting of the Council on Social Work Education, Fort Worth, Texas. March 13–16, 1983.

Wood, James L., and Maurice Jackson
1982 *Social movements: Development, participation and dynamics*. Belmont, CA: Wadsworth Publishing Co.

Yamamoto, Joe
1978a Research priorities in Asian American mental health delivery. *American Journal of Psychiatry* 135(4):457–458.
1978b Therapy for Asian Americans. *Journal of the National Medical Association* 70:267–270.

Yoshioka, Robert B., Nathaniel Tashima, and Margaret Chew
1981 *Mental health services for Pacific/Asian Americans*. Volume 1. San Francisco: Pacific Asian Mental Health Research Project.

Young, Jared J.
1977 *Discrimination, income, human capital investment and Asian Americans*. San Francisco: R and E Research Associates.

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About the Author

Paul Wong has been professor of research at the School of Social Work, Arizona State University since 1980. He received his B.A., M.A. and Ph.D. degrees from the University of California at Berkeley. He has also been on the faculty of the University of California at Berkeley, University of Illinois at Champaign-Urbana, University of California at San Diego, and the University of Hawaii. He was a faculty fellow at the Center for Advanced Studies in the Behavioral Sciences at Stanford in 1987. His books include *China's Higher Leadership in the Socialist Transition* and *Content Analyses of Documentary and Biographic Materials*. His articles have appeared in *Asian Survey*, *International Migration Contemporary Sociology*, *Social Casework*, *Journal of Education for Social Work* and other journals.

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45